MEDICARE AND MEDICAID BUDGET PRIORITIES IN THE 1990's

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 23, 1989

Comm. Pub. No. 101-724

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

99-881 ⇆ WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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MEDICARE AND MEDICAID BUDGET PRIORITIES IN THE 1990'S

THURSDAY, MARCH 23, 1989

U.S. House of Representatives,
Select Committee on Aging,
Washington, DC.

The Committee met, pursuant to notice, at 12:40 p.m., Room 2154, Rayburn House Office Building, Hon. Edward R. Roybal [Chairman of the Committee] presiding.

Members present: Representatives Roybal, Rinaldo, Oakar, Derrick, Vento, Borski, Volkmer, Manton, Kennedy, Bilbray, Jontz, Costello, Staggers, Pallone, Unsoeld, Regula, Fawell, Morella, Meyers, Schuette, and Bentley

Staff present: Manuel R. Miranda, Staff Director; Gary Christopherson, Director of Health Legislation; Yvonne Santa Anna, Professional Staff; Valerie Batza, Executive Assistant; and Carolyn Griffith, Staff Assistant.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Chairman Roybal. The Committee will proceed in its usual manner. I will make a very brief opening statement. A brief opening statement will be made by Mr. Rinaldo, and because Mr. Darman has to go back to a cabinet meeting, we are going to try to expedite the whole proceeding as much as possible.

I will ask the Members of the Committee to submit their opening statement for the record or make part of that statement at the time that they are recognized for questioning. In that way, we will be able to expedite the proceedings and make it possible for Mr. Darman to get to the cabinet meeting to which he is summoned.

Ladies and gentlemen, the purpose of today's hearing is to assess the impact of the 1990 Medicare and Medicaid budget proposal on beneficiaries and to begin an examination of Medicare and Medicaid priorities for the year 1990.

The administration's Medicare budget proposal for a $5 billion cut in fiscal year 1990, is the single biggest reduction in the budget. Their proposal targets a large cut in Medicare hospital payments and another huge increase in the already outrageously rising Medicare Part B premium.

Medicare Part B premiums under the administration's budget proposal would require beneficiaries to cover 25 percent of the program costs, a proposal expected to cost beneficiaries an extra $13 per month.

Today, I am releasing an analysis by the Committee based upon a study by the Health Care Financing Administration entitled, "Health Care Costs for America's Elderly." This study documents that America's elderly are getting into deeper and deeper financial trouble, even without further reduction in the budget. For example, in 1988, America's elderly were already paying 18.1 percent of their income for health care—up substantially from the 12.7 percent they paid in 1980; furthermore, in just two to three years, the elderly's out-of-pocket health care costs are likely to consume 20 percent of elderly income.

[The study referred to, "Health Care Costs for America's Elderly, 1977-88," March 1989, Comm. Pub. No 101-712, is available from the Committee upon request.]

These facts, ladies and gentlemen, are a matter that we will be discussing in this Committee. I ask unanimous consent that the balance of my opening statement be included in the record, and without objection, that will be the order.

[The prepared statement of Chairman Roybal follows:]

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The purpose of today's hearing is to assess the impact of the 1990 Medicare and Medicaid budget proposals on beneficiaries and to begin an examination of Medicare and Medicaid priorities for the 1990s.

The Administration's Medicare budget proposal for a $5 billion cut in fiscal year 1990, is the single biggest reduction in the budget. Their proposal targets a large cut in Medicare hospital payments and another huge increase in the already outrageously rising Medicare Part B premium. Medicare Part B premiums, under the Bush budget proposal, would require beneficiaries to cover 25 percent of program costs -- a proposal expected to cost beneficiaries an extra $13 per month by 1994.

Today I am releasing an analysis by the Committee based upon a study by the Health Care Financing Administration entitled Health Care Costs For America's Elderly. This study documents that America's elderly are getting into deeper and deeper financial trouble even without further budget cutbacks. For example, in 1988, America's elderly were already paying 18.1 percent of their income for health care -- up substantially from the 12.7 percent they paid in 1980. Furthermore, in just two to three years, the elderly's out-of-pocket health care costs are likely to consume 20 percent of elderly income.

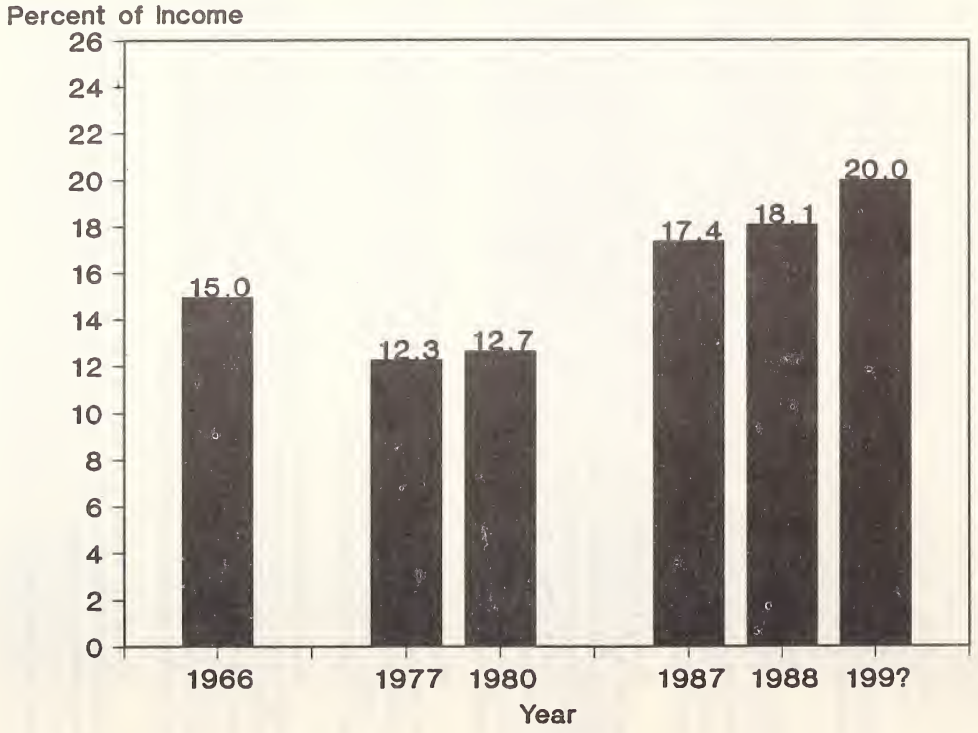
With respect to Medicaid, a program covering only about forty percent of poor Americans, the Bush Administration's budget proposes a Medicaid expansion without any real increase in funding. In a Nation noted for its failure to ensure health care access for 37 million uninsured Americans, the President's Medicaid proposal is at best a miniscule step toward redressing that failure.

From a historical perspective, since 1981, Medicare and Medicaid have undergone budget cuts. Under the pressure of rapidly rising costs for the federal government, there is little question that Medicare will face major changes in the 1990s. Therefore, as we enter the 1990s, it is imperative that the Administration and Congress assess the impact of the 1990 Medicare and Medicaid budget proposals on beneficiaries. We must be mindful that the pressures on beneficiaries goes beyond increasing costs and extends to their ability to access quality health care.

Now what remains to be seen is how mindful the Administration will be in regard to vulnerable Americans. I have grave concerns that the Executive Office of Management and Budget, not the Department of Health and Human Services, is setting the overall health policy, especially for Medicare and Medicaid. OMB's heavy hand in directing Administration health policy is extremely troubling for those of us trying to protect vulnerable Americans of all ages.

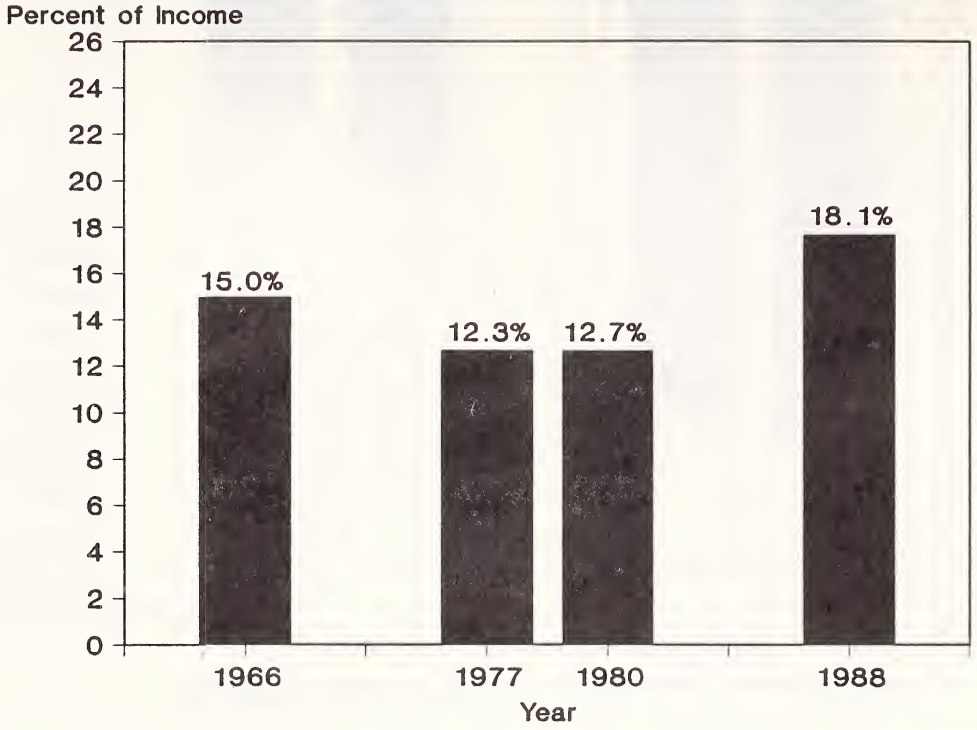
Elderly Health Care Costs

Consumer Costs as Percent of Income



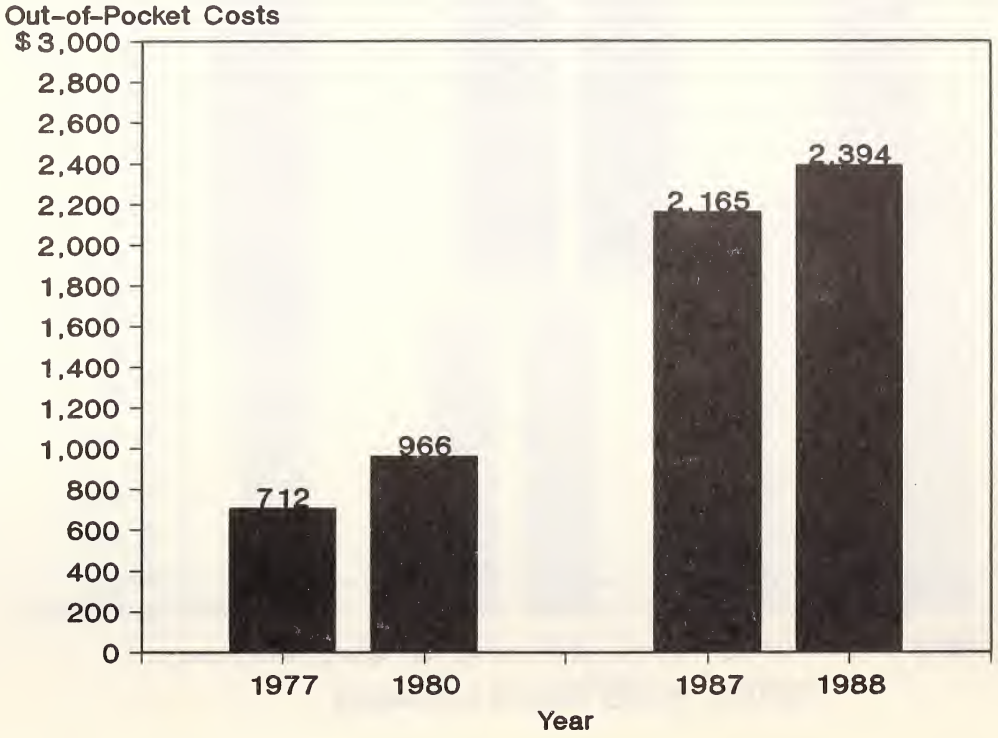
Elderly Health Care Costs

Consumer Costs as Percent of Income Compared to 1980



Elderly Out-of-Pocket Health Care Costs

Costs Per Capita for 1977-1988



Chairman ROYBAL. I will also now recognize Mr. Rinaldo for a brief opening statement.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mr. Chairman.

Mr. Chairman, I want to take this opportunity to welcome our very distinguished witness, Richard Darman, Director of the Office of Management and Budget.

And as you know, Mr. Chairman, 34 million elderly and disabled individuals rely on the Medicaid Program as their lifeline of quality health care, and that program enjoys unparalleled support among Members of Congress and the administration, and we have repeatedly demonstrated our commitment to fulfill Medicare's promise to this and future generations of the beneficiaries, so that they will never be without needed medical care because of cost.

And each year in the budget, we have had to fight, but we have been successful, by and large. The cuts that Medicare has sustained have come out of provider reimbursement and administrative expenses.

There are signs, however, that this system is under stress, and I want to say that I have had the opportunity, Mr. Chairman, to review the report that you are releasing today, and, as you know, it points out that beneficiaries are absorbing an ever-increasing share of their medical costs, and that these increases are out-stripping the rise in beneficiary income.

Now, many of these out of pocket costs stem from services never covered by Medicare. I just discussed a few moments ago with Mr. Darman some of the problems of long-term health care, nursing home care, things that are not covered and that present problems. Others arise from balanced billing by physicians whose prices are soaring and still others from cost containment measures, such as Medicare claims based on the capricious medical necessity standard.

Mr. Chairman, year after year, we go through this process, and I think after this year, it would probably be time to consider more fundamental reform. Our system is really out of balance with the health care needs of our elderly population, and in a field as comprehensive, as ever-changing as medical and long-term care, I do not think any policy can pretend to meet all needs for all times.

People are living longer, but not necessarily healthier. They have new, unmet needs. I think we have to get on with the job, and one way to do that is to rethink where our national health care resources are being allocated, try to come up with better ways of allocating them, try to provide a system of home health care and nursing home care, and perhaps reorient some of our priorities in ways that will enable government to achieve greater results without increased costs.

Thank you, Mr. Chairman. My statement goes on at some length, and what I would request at this time is unanimous consent that I can submit it in its entirety for the record, so as to not to delay Mr. Darman any further.

Ms. MEYERS. Mr. Chairman?

Chairman ROYBAL. Is there objection?

[No response.]

Chairman ROYBAL. There is none. It will be included in the record at this point along with all other prepared statements submitted by the Members of the Committee.

[The prepared statements of Representatives Rinaldo, Derrick, Borski, Sisisky, Manton, Costello, Regula, Lightfoot, Fawell, and Morella follow:]

PREPARED STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

GOOD AFTERNOON, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. WE'RE HERE TODAY TO DISCUSS THE ADMINISTRATION'S BUDGET PROPOSAL FOR THE MEDICARE AND MEDICAID PROGRAMS, AND TO EXAMINE THE IMPACT OF THOSE PROPOSALS ON BENEFICIARY ACCESS TO CARE.

MR. CHAIRMAN, 34 MILLION ELDERLY AND DISABLED INDIVIDUALS RELY ON THE MEDICAID PROGRAM AS THEIR LIFELINE TO QUALITY HEALTH CARE. MEDICARE ENJOYS SUPPORT AMONG MEMBERS OF CONGRESS AND THE ADMINISTRATION UNPARALLELLED BY ANY OTHER PROGRAM IN THE FEDERAL BUDGET EXCEPT SOCIAL SECURITY.

CONGRESS HAS REPEATEDLY DEMONSTRATED ITS COMMITMENT TO FULFILL MEDICARE'S PROMISE -- TO THIS AND FUTURE GENERATIONS OF BENEFICIARIES -- THAT THEY WILL NEVER HAVE TO DO WITHOUT NEEDED MEDICAL CARE BECAUSE OF COST.

WITHIN THE BUDGET CONTEXT, OUR CHALLENGE EACH YEAR HAS BEEN TO MEET DEFICIT REDUCTION TARGETS WITHOUT DIRECTLY INCREASING COSTS TO BENEFICIARIES AND WITHOUT PARING BACK SERVICES. BY AND LARGE, WE HAVE BEEN SUCCESSFUL. THE CUTS MEDICARE HAS SUSTAINED IN RECENT YEARS HAVE COME OUT OF PROVIDER REIMBURSEMENT AND ADMINISTRATIVE EXPENSES. WITH THESE WE HAVE MANAGED TO TRIM MOST OF THE FAT OUT OF THE PROGRAM WHILE LEAVING ITS BASIC BENEFITS AND COST SHARING ARRANGEMENTS INTACT.

THERE ARE SIGNS, HOWEVER, THAT THIS SYSTEM IS UNDER STRESS. I HAVE HAD AN OPPORTUNITY TO REVIEW THE REPORT CHAIRMAN ROYBAL IS RELEASING TODAY. THIS REPORT POINTS OUT THAT BENEFICIARIES ARE ABSORBING AN EVER-INCREASING SHARE OF THEIR MEDICAL COSTS, AND THAT THESE INCREASES ARE OUTSTRIPPING THE RISE IN BENEFICIARY INCOME. MANY BENEFICIARY OUT-OF-POCKET COSTS STEM FROM SERVICES NEVER COVERED BY MEDICARE, SUCH AS LONG-TERM HOME HEALTH CARE; OTHERS ARISE FROM BALANCE BILLING BY PHYSICIANS, WHOSE PRICES ARE SOARING; AND STILL OTHERS FROM COST CONTAINMENT MEASURES SUCH AS MEDICARE CLAIMS BASED ON THE CAPRICIOUS "MEDICAL NECESSITY" STANDARD.

MEDICAL PRICE INFLATION, WHICH MANY ARGUE IS DRIVEN IN PART BY THE INCENTIVES IN FEDERAL REIMBURSEMENT POLICY, COMPOUNDS THE PROBLEM. ACCORDING TO THE CHAIRMAN'S STUDY, SENIOR EXPENDITURES ON MEDICAL CARE HAVE GROWN AT TWO-AND-A-HALF TIMES THE RATE OF GROWTH IN SENIOR INCOME. MEDICARE'S PROMISE IS COMPROMISED BY THESE ESCALATING PRICES, AND BY OUR FAILURE TO CONTROL THEM.

CONGRESS HAS CREATED A BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE TO STUDY JUST THESE ISSUES. IN ADDITION, THE ADMINISTRATION HAS BEEN CONDUCTING ONGOING RESEARCH IN THE DEPARTMENTS OF TREASURY AND HHS INTO THE CHANGING NATURE OF OUR HEALTH CARE MARKET. NOTED HEALTH CARE ECONOMISTS ARE STUDYING WAYS TO RESTRUCTURE HEALTH CARE FINANCING AND DELIVERY IN THIS COUNTRY ALONG MORE RATIONAL AND EQUITABLE LINES.

IN ALL LIKELIHOOD, WE WILL GET THROUGH THIS BUDGET CYCLE AS WE HAVE THROUGH EVERY OTHER -- BY TINKERING WITH A FEE-FREEZE AND A MARKET-BASKET UPDATE, WHILE TRYING TO MINIMIZE THE IMPACT ON BENEFICIARIES AND LEAVING THE SYSTEM INTACT.

BUT AFTER THIS YEAR, I THINK IT IS TIME TO CONSIDER MORE FUNDAMENTAL REFORM. OUR SYSTEM IS OUT OF BALANCE WITH THE HEALTH CARE NEEDS OF OUR ELDERLY POPULATION. IN A FIELD AS COMPREHENSIVE AND EVER-CHANGING AS MEDICAL AND LONG TERM CARE, NO POLICY CAN PRETEND TO MEET ALL NEEDS FOR ALL TIME. IT IS TIME TO RE-THINK WHERE OUR NATIONAL HEALTH CARE RESOURCES ARE BEING ALLOCATED, AND PERHAPS TO REORIENT THEM IN WAYS THAT WILL ENABLE GOVERNMENT TO ACHIEVE GREATER RESULTS AT LOWER COSTS.

THANK YOU, MR. CHAIRMAN. I LOOK FORWARD TO HEARING FROM OUR WITNESSES.

PREPARED STATEMENT OF REPRESENTATIVE BUTLER DERRICK

Chairman Roybal, I want to comment you for focusing attention on the 1990 Medicare and Medicaid Budget Proposals. As you mentioned in your Opening Statement, The Administration's proposed $5 billion cut in Medicare is the single biggest reduction in the budget. We have a responsibility to the American people to ensure that the elderly and poor are shielded from further cuts which increase their out-of-pocket costs or reduce access to quality health care.

Health cost inflation is a problem faced by everyone but the elderly are especially vulnerable to the rises in health care cost. The cost of Medicare is increasing for several reasons: More people are living longer and thus need additional medical services; costly medical technology is advancing at a tremendous rate; and labor expenses are increasing at a rapid pace. The elderly are spending more and more of their incomes on health care. We must make sure that Medicare reimbursement is fair to providers and beneficiaries alike while still keeping a lid on the overall cost of the program.

Reimbursements for Hospitals

I have been flooded with impassioned appeals from individuals who are worried about the future of Medicare reimbursements for hospitals. Medicare rate increases have fallen well below increases in facilities' operating costs for the past six years. We have a serious federal budget deficit problem, but I believe that six years' sacrifice is enough!

Government health programs are especially important to rural hospitals. In South Carolina, Medicare, Medicaid, and Medically Indigent Assistance Fund patients are over half of the rural hospitals' business (60% of the patient days and 55% of the total charges).

Based on Medicare's figures, nearly half the nation's hospitals lost money on Medicare patients in 1987. The average Medicare profit for urban hospitals fell to 7.6%. The average Medicare profit for rural hospitals fell to 0.14%. Medicare pays rural hospitals less than urban hospitals for the same services. This is based on national studies that show rural hospitals have lower costs for goods and services. However, because of my home

state's size, these national figures do not make sense. Most (75%) of our "Medicare rural" hospitals are 40 miles or less from a "Medicare urban" hospital. Not only patients, but nurses and other health professionals commmute to these urban hospitals. Rural hospitals must pay higher salaries to compete. the 36 "Medicare rural" hospitals in South Carolina lost over $19 million in 1987 due to this Medicare policy. This penalty is especially hard on rural facilities since more of their patients are on Medicare.

Hospitals have made admirable improvements in efficiency, but there is no fat left to cut from the bone. It is important to the health of our economy as well as the public health to adequately reimburse hospitals for the services rendered to Medicare beneficiaries.

PREPARED STATEMENT OF REPRESENTATIVE ROBERT A. BORSKI

Mr. Chairman, first I want to thank you for holding this essential hearing to examine the affect of President Bush's budget proposal on the Medicare and Medicaid programs.

As you know, much of the Bush budget has been called a "black box" because it is long on proposals and short on specifics. While the President has promised a "kinder and gentler" nation, his single largest specific budget cut is taken from Medicare.

The Aging Committee held many hearings during the 100th Congress to identify critical gaps in older Americans' health coverage and to investigate policy options to fill those needs. Should this budget become law, the holes in coverage along with the elderly's omnipresent fears of bankrupting health care bills will only grow.

The bulk of the proposed $5 billion cut in Medicare would come from payments to hospitals. Last year, 81 hospitals closed and many more are on the brink of closing. Inadequate Medicare reimbursement is often cited as a major factor in the closure of these facilities. Further reductions in reimbursement is sure to trigger more hospital closings and limit access to health care, not only for Medicare beneficiaries, but for all Americans.

At the same time that hospital payments would be cut, Part B premiums would be allowed to skyrocket. While it is clear we must take action to curtail rising health care costs, we must not push more cost burdens on beneficiaries.

Part B premiums have risen an unprecedented 56 percent since 1980. In fact, out-of-pocket costs for health care eat up 18 percent of the elderly's income today, while in 1980 these costs represented only 12.7 percent of their income. In sum, Mr. Chairman, we cannot expect the elderly who live on fixed incomes to shoulder budget cuts while defense programs receive a full increase for inflation.

I was encouraged by the President's comments on February 9th when he stated that the federal government must honor its contract with the elderly. He was referring to the Social Security cost of living adjustment (COLAs). And while I wholeheartedly agree on that policy, I would also suggest that increases in out-of-pocket expenses for Medicare coverage reneges on that promise as much as the elimination of a COLA.

Similarly, the proposed Medicaid cutbacks sacrifice substantial reductions in certain program areas to allow minute increases in other coverage. In addition, the plan shifts the burden to make up shortfalls in federal Medicaid funds onto state budgets.

It is evident that this budget proposal cuts even deeper into the very programs which have already been unfairly burdened by reductions. These programs should provide a "safety net" for poor and older Americans, and we must not let budget proposals chip away any more of their protection.

Again, Mr. Chairman, I am very happy to be here to discuss these issues and to hear the testimony of our witnesses. I believe we must propose a workable budget plan which will reduce our deficit without severely limiting the protection that Medicare and Medicaid were set up to provide. Let's be honest about our budget responsibilities and the promises were made and not resort to back door budgeting or smoke and mirrors.

PREPARED STATEMENT OF REPRESENTATIVE NORMAN SISISKY

Mr. Chairman, I want to thank you for calling this hearing to focus on Medicare and Medicaid budget priorities in the next decade. Because a growing number of senior citizens in my district, the Fourth District of Virginia, are expressing their outrage over the high cost of medical treatment and rising Medicare premiums, I welcome today's discussion.

My constituents have become fearful of the future because year after year they hear news reports of severe cuts in Medicare and Medicaid. When told that the federal government is considering cutting Medicare spending by $5 billion dollars, older Americans understandably are concerned that they are going to be asked to spend a greater portion of their limited incomes on health care. And with the new catastrophic health legislation comes new concerns, questions and confusion.

In fact, Mr. Chairman I would like to take this opportunity to suggest that this committee consider holding a hearing to review the recent Medicare expansion in an effort to clear up some of the confusion and possibly examine proposals for improving the new law's financing provisions. I feel certain that most members are eager to respond in some positive way to the many constituents who have called and written to express concerns over this action we have taken.

Obviously our budget challenges are great, but so are our responsibilities. We owe it to our constituents to protect the integrity of the Medicare program. Ensuring quality and affordable health care must continue to be our objective. So, I particularly look forward to the testimony of the distinguished

Director of the Office of Management and Budget, as well as the testimonies of the other distinguished panelists. I hope the information you share with us will be the positive news my constituents have been waiting for.

Thank you.

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

MR. CHAIRMAN, I APPRECIATE YOUR SCHEDULING TODAY'S HEARING ON THE IMPACT OF PRESIDENT BUSH'S 1990 BUDGET PROPOSALS REGARDING MEDICARE AND MEDICAID. I LOOK FORWARD TO LEARNING MORE DETAILS ABOUT PRESIDENT BUSH'S INITIATIVES FOR OUR NATION'S SENIOR CITIZENS.

UNFORTUNATELY, THE REAGAN ADMINISTRATION HAS LEFT OUR NEW PRESIDENT A LEGACY ~~IS ONE~~ OF NEGLECT. DURING THE LAST EIGHT YEARS, PRESIDENT REAGAN REPEATEDLY SUBMITTED BUDGET PROPOSALS CONTAINING SEVERE CUTS IN MEDICARE AND MEDICAID. ACCORDING TO THE GENERAL ACCOUNTING OFFICE, FUNDING FOR MEDICARE WAS CUT BY $35.9 BILLION DOLLARS BETWEEN 1981 AND 1987. THESE ALARMING FIGURES WOULD HAVE BEEN MUCH HIGHER IF ALL OF THE PRESIDENTS PROPOSALS ENACTED. FOR EXAMPLE, THE ADMINISTRATION'S 1987 PROPOSALS ALONE WOULD HAVE CUT MEDICARE BY $54.5 BILLION AND MEDICAID BY $18.1 BILLION OVER A FIVE YEAR PERIOD.

AS WE APPROACH THE 1990S, THE PRESIDENT AND THE CONGRESS FACE ~~VENERABLE~~ SIGNIFICANT CHALLENGES. OUR FEDERAL BUDGET DEFICIT PLACES CONSTRAINTS ON FEDERAL SPENDING AND WILL REQUIRE US TO MAKE DIFFICULT CHOICES BETWEEN WORTHY PROGRAMS. HOWEVER, THE BUDGET DEFICIT SHOULD NOT BE USED AS AN EXCUSE FOR CUTTING NECESSARY SERVICES. DURING THE LAST EIGHT YEARS PRESIDENT REAGAN CONSISTENTLY MADE DRAMATIC CUTS IN SENIOR CITIZENS PROGRAMS, YET THE BUDGET DEFICIT CONTINUED TO GROW. OUR SENIOR CITIZENS ARE NOT RESPONSIBLE FOR OUR BUDGET CRISIS, AND IN A KINDER, GENTLER NATION, THEY SHOULD NOT BE ASKED TO SHOULDER A DISPROPORTIONATE SHARE OF THE CUTS NECESSARY TO BRING THE DEFICIT UNDER CONTROL.

MR. CHAIRMAN, I BELIEVE THIS COMMITTEE MUST CLOSELY EXAMINE PRESIDENT BUSH'S BUDGET PROPOSAL FOR FISCAL YEAR 1990. THIS BUDGET WILL SHOW WHAT PRIORITY PRESIDENT BUSH PLACES ON FEDERAL

PROGRAMS AND SERVICES WHICH ARE VITAL TO SENIOR CITIZENS.

FROM MY INITIAL READING OF THIS BUDGET, I AM TROUBLED BY THE LARGE CUTS IN MEDICARE FUNDING THAT HAVE BEEN RECOMMENDED BY THE PRESIDENT. IF THE GRAMM-RUDMAN AUTOMATIC SEQUESTRATION WERE TO OCCUR, CERTAINLY A DRASTIC MEASURE AND ONE THAT NO ONE WANTS, THE CUTS IN MEDICARE WOULD BE $1.5 BILLION. HOWEVER, PRESIDENT BUSH'S BUDGET PROPOSAL WOULD CUT MEDICARE OUTLAYS BY $5 BILLION. SOME OF THESE CUTS WOULD TRANSLATE INTO SHARP INCREASES IN MEDICARE PART B PREMIUMS FOR MEDICARE ENROLLEES. THIS WOULD BE A SEVERE HARDSHIP TO MANY OF MY CONSTITUENTS.

MR. CHAIRMAN, TODAY OUR COUNTRY IS UNDERGOING A DEMOGRAPHIC CHANGE. SENIOR CITIZENS ARE THE FASTEST GROWING SEGMENT OF OUR SOCIETY. THE ADMINISTRATION MUST WORK WITH THE CONGRESS TO REEXAMINE THE MEDICARE AND MEDICAID PROGRAMS. CONTINUING TO RAISE PREMIUMS WHICH SENIORS MUST PAY AND CUTTING REIMBURSEMENT RATES IN ORDER TO CUT COSTS IS NOT A REALISTIC WAY TO PREPARE FOR OUR FUTURE. THE PROBLEMS WE ARE FACED WITH TODAY WILL ONLY INCREASE AS OUR POPULATION AGES. THE DEMANDS MADE ON OUR MEDICARE SYSTEM WILL DRAMATICALLY INCREASE IN THE FUTURE. THE DIGNITY AND QUALITY OF LIFE AMERICAN SENIOR CITIZENS WILL HAVE TODAY AND IN THE FUTURE DEPEND ON HOW WE CHOOSE TO ADDRESS THIS IMPORTANT ISSUE.

MR. CHAIRMAN, ONCE AGAIN, I THANK YOU FOR CALLING THIS IMPORTANT HEARING, AND I LOOK FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES.

PREPARED STATEMENT OF REPRESENTATIVE JERRY F. COSTELLO

THIS MORNING'S HEARING ON MEDICARE AND MEDICAID PRIORITIES IN THE 1990 BUDGET COMES AT A CRITICAL TIME. SINCE I CAME TO CONGRESS LAST FALL, I HAVE HEARD EXTENSIVELY FROM SENIOR CITIZENS IN MY DISTRICT ABOUT THEIR CONCERN REGARDING THE MEDICARE PROGRAM AND POSSIBLE CUTS IN SERVICES.

PRESIDENT BUSH'S 1990 BUDGET PROPOSALS HAVE YET TO OFFER THESE CITIZENS ANY ENCOURAGEMENT ABOUT THE FUTURE OF THE MEDICARE PROGRAM. PRESIDENT BUSH HAS CALLED FOR $5 BILLION IN CUTS IN THIS PROGRAM, A CUT IN OUTLAYS FAR

BELOW THE LEVELS NEEDED TO PROVIDE BENEFITS UNDER CURRENT LAW. CUTS IN THIS PROGRAM WILL HAMPER THE MEDICAL SERVICES PROVIDED TO OUR SENIORS. CERTAINLY IN THIS TIME OF BUDGET DEFICITS WE CAN FIND A MORE REASONABLE AREA TO TARGET FOR BUDGET CUTS THAN BASIC MEDICAL CARE FOR OLDER AMERICANS.

HOWEVER, I DO SUPPORT THE PRESIDENT'S INITIAL INDICATIONS TO INCREASE SOME FUNDING IN THE MEDICAID PROGRAM. MEDICAID PROVIDES HEALTH CARE FOR THE MOST NEEDY, LOW-INCOME PERSONS IN AMERICA. OLDER AMERICANS, SMALL CHILDREN, PREGNANT WOMEN, AND THE DISABLED IN OUR COUNTRY NEED THE GOVERNMENT'S HELP, AND MEDICAID IS ONE PROGRAM THAT PROVIDES THEM WITH ADEQUATE HEALTH CARE.

ONE OF THE MAJOR CONCERNS IN MY DISTRICT CONCERNS INFANT MORTALITY. ILLINOIS WEARS THE UNFORTUNATE LABEL OF BEING ONE OF THE WORST STATES IN THE COUNTRY IN TERMS OF INFANT MORTALITY. ONE OF THE MOST IMPORTANT PROVISIONS IN THE PRESIDENT'S FUNDING PROPOSALS WILL EXPAND COVERAGE FOR PREGNANT WOMEN AND INFANTS UP TO 185% OF THE POVERTY LEVEL, INCREASING THE NUMBERS OF WOMEN WHO WILL RECEIVE THE NECESSARY PRENATAL CARE FOR A HEALTHY DELIVERY.

I AM HOPEFUL THAT PRESIDENT BUSH AND DIRECTOR DARMAN WILL WORK WITH US TO REACH A COMPROMISE ON THE MEDICARE PROGRAM AND TO MAKE THIS MEDICAID INCREASE LAW SO THAT WE CAN CONTINUE TO PROVIDE QUALITY HEALTH CARE TO THOSE AMERICANS WHO CANNOT AFFORD IT.

PREPARED STATEMENT OF REPRESENTATIVE RALPH REGULA

I commend you for your efforts in conducting this hearing on Medicare and Medicaid budget priorities.

In 1989, Medicare will provide health insurance for an estimated 33 million persons who are aged, disabled, or suffer from end-stage renal disease. Federal outlays for the program are expected to increase 11% annually from 1988 to 1993. This means an increase from $79 billion in 1988 to $128 billion in 1993. This increase significantly exceeds general inflation and the increase in the beneficiary population.

Since the enactment of Medicare the federal government's share of our nation's health care costs has increased from 10% in 1965 to 27% in 1975 and more slowly to 30% in 1986. These figures reveal the problems posed by Medicare as a rapidly growing federal entitlement program with escalating costs.

Congressional efforts, most notably the Prospective Payment System (PPS), have decreased costs in the hospital setting and caused many institutions to become more efficient. However, they have also resulted in problems with access and premature discharges from care. Moreover, some of the savings are illusory in that the cost is being passed onto other third party payers. As private insurers and the states tighten their reimbursement plans caregivers are confronted with lower revenues and the possibility of rationed care or decreased services.

I am especially interested to hear the comments of Mr. Darman concerning further cost controls under Part A and his opinion regarding their impact upon access and quality.

Another consideration is physician reimbursement under Part B. These payments are growing at more than 12% a year. Perhaps our distinguished panel can comment on recent proposals set forth by the Prospective Payment Commission and the Harvard study to redesign physician payment methodology. As indicated by these reports it is the quantity and intensity of these treatments rather than the actual costs which are driving these increases.

Finally, I would like to commend the administration on their efforts to expand coverage of the medically indigent. In his message to Congress, President Bush said the development of a Medicaid "buy-in" and expansion of coverage under the program was a top health priority of his administration. Legislation has incorporated his proposal to require states to extend services to pregnant families with income below a certain percentage of the poverty level.

I look forward to the insights our witnesses will provide on these important issues.

PREPARED STATEMENT OF REPRESENTATIVE HELEN DELICH BENTLEY

I would like to thank the Chairman for calling this hearing today for one very important reason: the effect of "growth" restraints on Medicare and Medicaid beneficiaries.

The program was designed to assist beneficiaries with health care and other related expenses. Because program costs have continued to increase (expenditures have more than doubled every seven years) there is a need to contain costs. This is true for the entire health care industry and our notice is not restricted solely to Medicare.

However, if cost containment measures continue as they have, the Medicare beneficiary will be shortchanged. Although many of the growth curbs are targeted at hospital and physician service reimbursement rates, these measures directly affect the beneficiary.

A trade off is necessary--Congress is left to decide if physicians and hospitals are profiting unduly from Medicare, while hospitals and physicians are left wondering whether they will be forced to push Medicare patients out of their hospitals and offices.

We are trying to supply a service to a rapidly growing constituency in an environment of increasingly limited resources. If you think our problems are bad now, wait around for another decade and look again. We must ask ourselves why health care costs are so exorbitant. Or for that matter, why is the cost of living so high.

I suggest that we look at the whole picture when considering the Medicare and Medicaid budget. Medicare is calling our attention to the underlying economic problem in this nation--that of the budget deficit. If not given serious attention, the budget will slowly drive all our costs of living through the ceiling; leaving our nation with very few alternatives.

PREPARED STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

MR. CHAIRMAN, THANK YOU FOR SCHEDULING A HEARING ON PRESIDENT BUSH'S PROPOSED MEDICARE AND MEDICAID BUDGET FOR FISCAL YEAR (FY) 1990. THE SIGNIFICANCE OF THE MEDICARE AND MEDICAID BUDGET HAS A TREMENDOUS IMPACT ON THE QUALITY OF LIFE FOR ITS BENEFICIARIES AND OUR NATION'S HEALTH CARE DELIVERY SYSTEM. I LOOK FORWARD TO HEARING FROM OUR WITNESSES ON THIS IMPORTANT ISSUE. IN ADDITION, I AM PLEASED THAT MR.

RICHARD DARMAN, DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET, IS HERE TO DISCUSS THE PRESIDENT'S PROPOSALS. THANK YOU FOR COMING.

MR. CHAIRMAN, I AM PARTICULARLY CONCERNED WITH HOW THE PRESIDENT'S PROPOSED REDUCTIONS IN M DICARE PAYMENTS TO HOSPITALS AND PHYSICIANS WILL IMPACT OUR RURAL HEALTH CARE DELIVERY SYSTEM. AS YOU KNOW, I REPRESENT A PREDOMINANTLY RURAL AND ELDERLY CONGRESSIONAL DISTRICT. THE URBAN-RURAL DIFFERENTIAL HAS PLAYED A SIGNIFICANT ROLE IN THE FUTURE OF OUR NATION'S RURAL HOSPITALS. RURAL HOSPITALS ARE MORE VULNERABLE TO MEDICARE REDUCTIONS THAN THEIR URBAN COUNTERPARTS BECAUSE THEY DEPEND ON MEDICARE PATIENTS FOR THEIR ADMISSIONS. FOR EXAMPLE, A 40 BED HOSPITAL CAN EXPECT 80 PERCENT OF ITS BEDS TO BE FILLED BY MEDICARE BENEFICIARIES. IN 1988, 102 HOSPITALS CLOSED THEIR DOORS. SEVERAL OF THESE OCCURRED IN RURAL AREAS; MANY WERE THE ONLY HOSPITAL IN THE COMMUNITY AND OFTEN THE ONLY ONE IN THE COUNTY. THE IMPACT OF LOSING A HOSPITAL OFTEN HAS A NEGATIVE RIPPLING EFFECT ON THE ENTIRE COMMUNITY. RURAL BUSINESSES LOSE COST-EFFECTIVE PROVIDERS AND COMMUNITIES LOSE A PRECIOUS COMMODITY - THEIR LOCAL HEALTH CARE RESOURCES.

FOR RURAL ELDERLY, HOSPITAL CLOSURES MEAN TRAVELING GREATER DISTANCES TO A PHYSICIAN OR A HEALTH CARE FACILITY. HOW WOULD YOU REACT IF YOUR AGING PARENT FACED A LIFE OR DEATH SITUATION AND THE CLOSEST HOSPITAL WAS 60 MILES AWAY? A HIGH PERCENTAGE OF OLDER AMERICANS EXPERIENCE LIFE THREATENING ILLNESSES WHERE IMMEDIATE CARE IS WARRANTED. PROXIMITY COUNTS!

THE PRESIDENT HAS ALSO PROPOSED REDUCING MEDICARE PAYMENTS TO PHYSICIANS. MANY RURAL COMMUNITIES CONTINUE TO HAVE PROBLEMS IN RECRUITING AND RETAINING HEALTH CARE PROFESSIONALS TO SERVE THEIR NEEDS. SPECIALISTS ARE LEAVING RURAL COMMUNITIES AND MOVING ON TO URBAN AREAS OR EVEN OUT OF STATE. CHANGES IN THE MEDICARE AREA WAGE INDEX COULD HAVE A SIGNIFICANT IMPACT IN ADDRESSING THE PROFESSIONAL SHORTAGE THAT MANY RURAL HOSPITALS ARE NOW FACING.

I LOOK FORWARD TO OUR PANELS' INPUT ON HOW FURTHER MEDICARE AND MEDICAID BUDGET CUTS WILL IMPACT ACCESS TO QUALITY AND AFFORDABLE HEALTH CARE SERVICES FOR OUR NATION'S ELDERLY. THANK, YOU MR. CHAIRMAN.

PREPARED STATEMENT OF REPRESENTATIVE HARRIS W. FAWELL

Mr. Chairman, I am pleased to have the opportunity this afternoon to welcome our distinguished guests and listen to their thoughts and feelings on federal spending for health care.

President Bush has proposed reducing Medicare expenditures to $5 billion below full inflationary increases, for a total expenditure in 1990 of $105.8 billion. This reflects an increase of 10.4 percent more than the current estimated expenditures for 1989. Without the President's legislative proposals reducing expeditures for 1990 by $5 billion, the rate of increase for Medicare would be 14 percent.

Medicare and Medicaid programs currently consume 31 percent of the entire budget for all federal health and human service programs, including public health, AIDS research and education, the National Institutes of Health, Social Security, and welfare. Without implementing some cost controls on Medicare, this program alone will exceed spending for defense and Social Security combined by 2012. This would surely constrain the allocation of federal funds for other vital programs. Hopefully, the spending reforms for Medicare will help control the current staggering growth rate, which is three and a half times the inflation rate. These reforms will ensure that the federal government can continue to provide necessary medical care to its senior and disabled population in future years.

While I generally support efforts to control runaway health care costs, I am wary of doing so when the quality and accessability of care may be jeopardized. I look forward today to hearing the specific recommendations for reducing costs and understanding better the impact such reductions could have on our nation's senior and low-income citizens and the institutions which provide them with the care they need. I want to ensure that we are not trimming spending in this area at jeopardy to the quality of health care rendered in this country.

With that said, I look forward to hearing from our guests.

PREPARED STATEMENT OF REPRESENTATIVE CONSTANCE A. MORELLA

MR. CHAIRMAN, THANK YOU FOR SCHEDULING THIS HEARING TODAY TO ASSESS THE IMPACT OF THE 1990 MEDICARE AND MEDICAID BUDGET PROPOSALS ON BENEFICIARIES, AND TO BEGIN AN EXAMINATION OF MEDICARE AND MEDICAID PRIORITIES FOR THE 1990'S.

THIS SUBJECT IS VERY RELEVANT AT A TIME WHEN WE MUST FACE THE CHALLENGE OF BALANCING NOT ONLY THE FEDERAL BUDGET, BUT ALSO COMPETING HEALTH CARE PRIORITIES. I AM SERIOUSLY CONCERNED WITH THE ADMINISTRATION'S PROPOSED REDUCTIONS IN THE MEDICARE PROGRAM. CONTINUED PRESSURE ON PROVIDERS COULD BE PARTICULARLY HARMFUL TO SPECIFIC POPULATIONS, SUCH AS THE MEDICALLY INDIGENT AND THE ELDERLY.

I APPRECIATE THE OPPORTUNITY TO EXAMINE THESE ISSUES WITH THE DISTINGUISHED PANEL WE HAVE BEFORE US TODAY. I AM CONFIDENT THAT WE CAN WORK TOGETHER TO ADDRESS THE HEALTH CARE NEEDS OF BOTH THE POOR AND THE ELDERLY.

Ms. MEYERS. Mr. Chairman? May I ask a question?

Chairman ROYBAL. The lady is recognized.

Ms. MEYERS. Mr. Chairman, I may be confused, but I think that the administration budget reflects a 10 percent increase over last year's amount that was expended. It goes from, I think, $86 billion to $95 billion, is that not correct?

Chairman ROYBAL. If I understand you, that is correct, but only in Medicaid.

Ms. MEYERS. No. It is Medicare.

Chairman ROYBAL. That will have to be clarified then as we have this discussion. My understanding is that it is Medicaid, but whatever the situation, I think that we can cover that in the question and answer period, and actually establish the two recommendations of the administration with regard to Medicare and Medicaid.

Ms. MEYERS. Thank you, Mr. Chairman.

Chairman ROYBAL. The Chair has the pleasure of introducing the Director of the Executive Office of Management and Budget.

Richard Darman is a man of great experience. I will have the opportunity of meeting him again when he appears before another Committee which I am Chairman, and that is the Committee on Treasury, under the Committee on Appropriations.

As you know, the Appropriations Committee is actually the Committee that appropriates. All the other committees of the House and the Senate are authorizing committees, and at that time, we will be discussing the budget with regard to the Department of Treasury.

At this time, we are looking into another phase of the budget that has been submitted, and that is the impact that the administration's Medicare and Medicaid budget proposals will have on beneficiaries. I think that is the focus of this hearing.

The Chair now is pleased to recognize Mr. Richard Darman.

STATEMENT OF RICHARD G. DARMAN, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT

Mr. DARMAN. Thank you very much, Mr. Chairman.

Chairman Roybal, Congressman Rinaldo, distinguished Members of the House Select Committee on Aging, I am pleased to appear before you today to discuss the President's Medicare proposals and the need to constrain the growth in Medicare program costs.

I might say as an aside, Mr. Chairman, that I have fond memories from my early days at HEW in the late sixties and early seventies when I was associated with the then Cabinet Committee on Aging. In those days, it was, if I might say, a lot more fun because in those days, we were figuring out how to expand benefits under every heading, and we were not too concerned about costs. As I know you and other Members of the Committee will recall well, at one point we got into a bidding war on Social Security and ultimately passed the 20 percent Social Security benefit increase, which had a very favorable effect on the income position of older Americans.

We see that improved position reflected today, but, in any case, the topic we have to discuss today is not quite so popular, and it is

not quite so comfortable a position to be in as it was almost a couple of decades ago.

That said, let me say that the prepared statement, which you all have before you I believe, presenting the administration's views, is a relatively lengthy one. With your permission, I would make a few introductory remarks and then ask that the remainder of the prepared statement be included in the record.

Chairman ROYBAL. Will you please proceed, Mr. Darman, in analyzing your statement? Your written statement will appear in the record in its entirety.

Mr. DARMAN. Thank you very much, Mr. Chairman.

A few propositions seem to me to be evident and compelling. The first, there is an obvious need to get our fiscal deficit down. This is not a partisan matter. It is a matter of practical necessity. If we do not get the deficit down, there will be a regrettable price to be paid in human terms by both young and old, both the current generation and future generations.

Second, Medicare is not only a large portion of the Federal budget, it is also one of the most rapidly growing portions. The growth of Medicare must be restrained in any balanced approach to restraint on Federal spending growth.

Third, if the rapid growth of Medicare is not restrained, we will not only fail to reduce our fiscal deficit satisfactorily, we will also, inevitably, deprive other worthy programs, including important domestic spending programs.

Fourth, while we clearly must restrain the growth of Medicare, we must do so in a way that, to the maximum extent possible, avoids adverse impact on Medicare beneficiaries.

Fifth, in seeking to restrain the growth of Medicare, we should not be fooled by the wonderland budgeting habits of current services budgeters. We should achieve restraint on the growth of program costs that is, in fact, greater restraint than is associated with the status quo.

And if I could, Mr. Chairman, I would conclude my remarks in just a couple of more minutes by elaborating on this last point because it is a point raised by Congresswoman Meyers' question.

The Congresswoman asked, in effect, under current services, is it not the case that Medicare expenditures would rise from fiscal year 1989 to fiscal year 1990 by about $13 billion, and the answer is yes, that is our estimate and CBO's estimate.

Medicare, under current law, would rise by about $13 billion.

Under the President's proposals, Medicare would rise by about $8 billion, and, so, it is the difference between that 8 and the 13 that people would call a "cut" under some ways of accounting, or a "savings".

In fact, of course, under either alternative, Medicare will be increasing by a very substantial amount, $8 billion under our proposal. If I could take just a minute more on this point, because I think it is quite an important one, of the $13 billion increase, compared with the $8 billion, that difference of $5 billion, almost $2 billion of that difference of $5 billion is accounted for, or could be, merely by the extension of current provisions.

To be less abstract, the increase of $13 billion is based on the current law assumption that the 85 percent reimbursement for capital

costs would disappear, that the 25 percent floor on supplementary medical insurance premiums would disappear, and that a lesser provision in terms of its dollar effect, involving the treatment of clinical lab reimbursements, would also disappear.

If you assume that those would all disappear, then, indeed, the increase would be $13 billion. If you assumed, however, that they would stay exactly as they are now, the increase would be almost $2 billion less. It would be about $11 billion.

So, putting it the other way around, of the $5 billion that the President's proposals are sometimes said to be cutting, $2 billion of that is merely the extension of the existing provisions.

I might complicate this a little bit further by saying that if you were to add in the coverage of State and local government employees under Medicare, the ones who are not now covered, that is the so-called old employees, pre-1986 employees, if you were to add those in, then the Medicare Trust Fund would be a net gainer by $1.8 billion.

If you added up all of these considerations, the so-called cut in Medicare would really be a cut of only $1.2 billion, and putting it in the terms that I would prefer to put it in, we would still be increasing Medicare very substantially.

All of that said, and I am sure you will want to come back to that at some point, I do think the more fundamental point that we have to look at is that this system is growing so rapidly and it is so large that it threatens to create what some have called a Pac-Man Phenomenon, where the steady, very rapid growth of Medicare, for perfectly good reasons that most would support, threatens gradually to eat up indirectly the potential growth of all kinds of other domestic programs in the budget.

I might say as an aside, we are seeing exactly that phenomenon in the budget negotiations in which I am now participating. As one looks for a "fair way" to restrain the growth of government, there is a tendency in the political system to say, well, Defense ought to give so much, and non-Defense ought to give so much, and though I do not think that is a rational way to look at things, it is the way the political system tends to be looking at things, and if you look at things that way, you start with a given desired level of restraint on domestic spending growth.

Every dollar less that is saved under Medicare is a dollar less that will be spent under some other heading in domestic spending. That is what I would call the Pac-Man Phenomenon. Gradually, Medicare is eating the rest of the budget, and that cannot continue.

It is not a question of whether the Bush administration will stop it from continuing or not, or this Congress will. It is a practical matter of fact. It cannot continue forever. We may not restrain it adequately in the near term. Eventually, the phenomenon will have to be stopped. It stops itself.

In any case, I would say that what we ought to be doing is trying to find a relatively rational way to restrain the growth on an orderly basis, before we reach the point at which others in the system start to conclude that the Medicare growth is becoming so astronomical and threatening other worthy domestic objectives so much, that you have at some stage an irrational reaction against the Medicare system, which I think none of us would like to see,

but which is at some stage a threat if we do not get this under control on an orderly basis.

That said, Mr. Chairman, I will conclude these introductory remarks, and look forward to responding to your questions and the questions of other distinguished Members of the Committee.

[The prepared statement of Mr. Darman follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

INTRODUCTORY REMARKS:

PRESENTED BEFORE

THE HOUSE SELECT COMMITTEE ON AGING

BY

RICHARD G. DARMAN

DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET

MARCH 23, 1989

Chairman Roybal, Congressman Rinaldo, and distinguished members of the House Select Committee on Aging, I am pleased to appear before you today to discuss the President's Medicare proposals and the need to constrain the growth in Medicare program costs.

The prepared statement presenting the Administration's views is relatively lengthy. With your permission, I would make a few introductory points, and then ask that the remainder of the prepared statement be included in the record.

A few propositions seem to me to be evident and compelling:

(1) There is an obvious need to get our fiscal deficit down. This is not a partisan matter. It is a matter of practical necessity. If we do not get the deficit down, there will be a regrettable price to be paid -- in human terms -- by both young and old, both the current generation and future generations.

(2) Medicare is not only a large portion of the federal budget, it is also one of the most rapidly growing portions. The growth of Medicare must be restrained in any balanced approach to restraint on federal spending growth.

(3) If the rapid growth of Medicare is not restrained, we will not only fail to reduce our fiscal deficit satisfactorily, we will also -- inevitably -- deprive other worthy programs (including important domestic spending programs).

(4) While we clearly must restrain the growth of Medicare, we must do so in a way that -- to the maximum extent possible -- avoids adverse impact on Medicare beneficiaries.

(5) In seeking to restrain the growth of Medicare, we should not be fooled by the Wonderland budgeting habits of "current service" budgeteers. We should achieve restraint on the growth of program costs that is, in fact, greater restraint than is associated with the status quo.

U.S. Resources Are Increasingly Devoted to Health Care:

Since 1965, when Medicare was created, health care has been consuming an increasing proportion of our Gross National Product, from 6.0 percent of GNP in 1965 to 11.1 percent in 1986.[1] Over the same period, the Federal government's share of national health care expenditures more than doubled, from 13 percent in 1965 to 29 percent in 1986.[2] As a nation, we are spending more of our resources on health, and the Federal government has been assuming increased responsibility for allocating those resources among providers.

Viewed internationally, U.S. health care spending continues to increase relative to other industrialized nations. A recent summary of international spending data indicates that the average ratio of health expenditures to Gross National Product (GNP) in the twenty-four Organization for Economic Cooperation and Development (OECD) countries has stabilized at about 7.2 percent since 1980, while the U.S. ratio has increased steadily over the same period (from 9.2 percent to over 11 percent)[3].

High Health Expenditures Threaten Domestic Fiscal Balance:

Had we been able to keep health care's claim on GNP constant at the 1980 percentage, over $75 billion per year in national income would have been available for re-allocation from medical care to other goods and services. Assuming a 29 percent Federal government share of national health expenditures, these GNP savings would translate into about $22 billion in annual budget savings.

Put another way, if we were able to keep health care expenditures at the same share of GNP in 1990 as in 1989, and assuming a constant 29 percent Federal share of health expenditures, the FY '90 Federal budget would be $5 billion lower.

Not only are health care expenditures consuming more and more of our GNP, but Medicare's share of the Federal budget is also increasing. To illustrate, assuming Medicare expenditures were to continue to grow at the "current services" rates, Medicare spending would overtake either defense spending or Social Security in 2005. Just 10 years later, in 2015, Medicare would exceed the combined total of defense and Social Security. While the forthcoming Medicare and Social Security Trustees' reports could refine these projections, the general point remains: absent fundamental reform, Medicare will consume an ever-increasing portion of the Federal budget. Unchecked growth in Medicare spending, in turn, will crowd out opportunities to invest not only in national security, but also in important domestic priorities.

Excessive Medicare Growth Distorts Use of the Nation's Resources:

Changing Medicare incentives is essential if we are to moderate growth in the high level of U.S. GNP devoted to health. Our budgetary goal should be to align growth in overall health care spending with growth in our GNP.

Unfortunately, changes in Medicare are complicated by the peculiar nature of the United States health care system. Over time, the system has evolved to one where consumers are largely insulated from the costs, and practitioners face only fragmented market pressures. Classic market disciplines are virtually non-existent. Third-party payors, Medicare included, face a partially competitive, partially regulated system -- a hybrid that is growing beyond control.

The U.S. health care system presents payors, providers, and beneficiaries alike with a bewildering set of often contradictory policies and incentives. Medicare policy is situated in the no-man's land between regulation and competition, relegated to proposing and enacting second-best solutions.

As a society, we can no longer afford to sustain the current rates of increase in either Medicare or national health care spending. The President's budget proposals are a starting point for restraint -- even if only that -- and I look forward to working with you and your colleagues in addressing the issues outlined in this testimony.

President's Budget -- Extensions, Reforms, and Coverage:

Let me describe briefly the President's Medicare proposals. They fall into three general categories: first, extensions of current law; second, additional restraints on growth; and third, extension of coverage to all State and local employees. Under the first category, the budget assumes continuation of three current policies: 1) a 25 percent floor on the Part B premium; 2) payment of hospital capital at 85 percent; and 3) continuation of the current payment method for clinical laboratories. If the Congress were to allow these three policies to expire, Medicare spending would increase by about $1.8 billion above the level assumed in the President's budget. Or, conversely, if the Congress were to extend these three current policies, Medicare would increase by about $1.8 billion less.

Under the second category, the budget proposes a number of hospital and physician payment reforms, with no adverse impact on beneficiaries. These include: 1) adjusting the Prospective Payment System (PPS) update factor to encourage cost-reducing behavior by hospitals; 2) reflecting declining hospital occupancy rates in Medicare's capital payment policy; 3) incorporating the latest analyses in determining the indirect medical education add-on; 4) reducing the payment levels for certain overpriced physician procedures; and 5) reducing payments to overpaid specialties.

Under the third category, the President proposes to extend valuable Medicare Hospital Insurance (HI) coverage to State and local employees hired before April 1, 1986. (COBRA extended HI coverage to State and local workers hired after March 31, 1986). Some of these "old" State and local employees are not assured of any medical coverage when they retire and could be faced with major out-of-pocket medical cost or be forced onto the Medicaid rolls. Other noncovered State and local workers will drain the HI trust fund as they, and their agencies, receive valuable HI benefits but do not pay the HI tax as other employers and workers must do. The Department of Health and Human Services Inspector General found that 85 percent of employees exempt from HI coverage in their State and local employment received the full range of HI benefits anyway through their spouses' record, or through short periods of work in covered employment. The President's budget proposal would ensure that State and local employees, like other workers, receive valuable Medicare coverage and pay their fair share into the HI trust fund. This extension of HI coverage, proposed to be effective October 1, 1989, is estimated to increase receipts to the HI trust fund by some $2.0 billion in 1990.

Physician Spending -- Out of Control:

Medicare Supplementary Medical Insurance (SMI) pays for a wide range of physician and other medical services. Physician payments account for 68 percent, or $27 billion, of total SMI spending in FY '89. Payments to hospital outpatient departments account for 21 percent, or $8.3 billion, in FY '89. Independent labs will receive $1.2 billion, physician office labs and outpatient labs another $1.5 billion.

Projected to spend $46 billion in FY '90, Supplementary Medical Insurance (SMI) does not function like a classic trust fund. The SMI trust fund lacks a unique, dedicated revenue source permanently appropriated to it. Consequently, there exists no looming threat of bankruptcy, no widely apparent urgency to protect the trust fund. The narrow view of the financing structure masks the inherent budgetary problems underneath.

Government spending on SMI will reach $29.5 billion in FY '89 and $34.8 billion in FY '90. Under current law, the government will contribute 17.7 percent more to the program every year from 1989 to 1994, a 126 percent increase over just these five years.

When SMI was originally established in 1965, its annual costs were to be funded half by monthly premiums paid by beneficiaries and half by an annual, open-ended general fund (subsidy) appropriation. In 1971, when Social Security added a cost-of-living adjustment (COLA) tied to the annual percent increase in the consumer price index (CPI), annual SMI premium increases were limited to the lesser of the COLA (i.e., the percent increase in the CPI) or the increase in per capita SMI program costs. Between 1972 and 1982, the annual growth rate in SMI program costs averaged 21 percent, while the CPI averaged 8.8 percent. Beneficiary premiums fell from 50 percent to 23 percent of SMI financing. Concomitantly, the federal subsidy rose from $1.2 billion in 1972 to $11.4 billion, or 77 percent of SMI costs in 1982.

Beginning with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress stabilized the premium at 25 percent of SMI program costs. The provision was extended in two subsequent reconciliation measures, with the last extension enacted in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87).

25% Premium Essential To Moderating Part B Growth Rates:

Under current law, the 25 percent premium/75 percent general fund subsidy financing -- expires on December 31,

1989. By 1994, the general fund subsidy would soar to financing 83 percent of SMI, totalling $66.7 billion. The Administration believes it is critically important to extend the 25 percent premium. Simply extending current law will result in $700 million in FY '90 savings (and $12 billion in 1990-94).

The effect of continuing current premium policy on the 1990 premium is $1.40 per beneficiary per month. While poverty rates for the elderly have declined significantly since the birth of Medicare, from 28.5 percent in 1966 to 12.4 percent in 1986,[4] even $1.40, in isolation may be burdensome for some elderly. However, Medicaid pays the SMI premium (as well as other cost sharing) for approximately 500,000 low-income Medicare beneficiaries. Additionally, the existing SMI "hold harmless" provision assures that beneficiaries will not suffer an absolute reduction in their Social Security check due to an increase in the SMI premium (which is typically deducted from an individual's monthly benefit before the check is mailed).

Maintaining the SMI premium at a constant share of program costs is critical for maintaining a broad societal consensus for limiting SMI -- particularly physician -- spending increases. Were the annual premium increase limited by the COLA percent increase, beneficiaries would be indifferent between a 5 percent annual SMI increase and a 25 percent increase, since their premium costs would be unaffected. With a constant share of program costs covered by the premium, though, they would have a clear financial incentive to support efforts to control Medicare costs. The purpose of extending the premium floor is not to place an unfair burden on the elderly, but rather to create incentives for restraint by sharing the growing costs of the program.

Physician Spending Drives Part B Growth:

Physician payments grew an average of 15 percent each year between 1980 and 1989, in a so-called era of cost-containment. From 1977 to 1985 physician payments grew 19 percent annually. Although the nominal rate of increase has slowed, the real rate of growth has not come down. Without further restraint, physician payments will increase another 80 percent from FY '89 to FY '94, reaching $48.4 billion.

In addition to direct reimbursement to physicians, Medicare pays for outpatient hospital care, diagnostic tests, durable medical equipment, and other health-related services which physicians order. Growth in these areas has matched or outpaced physician expenditures. Lab and

outpatient hospital reimbursements grew more than 20 percent last year and are expected to continue this disturbing trend for the foreseeable future.

What is feeding this seemingly inexorable trend toward greater and greater spending on physician services? Let's begin by putting into perspective some of the conventional explanations for this growth. Annual growth in size of the beneficiary population accounts for only 1.9 percent of the annual expenditure increase. Aging of the Medicare population (i.e., older people are generally sicker and need more services) accounts for only another 1 percent of the annual increase.

Physician Fees Fuel Part B Physician Spending:

Physician fees, or the amount Medicare pays per service, account for approximately 5 percent of expenditure growth despite efforts to constrain these fees. When Medicare was created in 1965, the legislation provided for minimal restrictions on the amount physicians could bill Medicare. In subsequent years, the increase in an individual physician's reimbursements per service depended on the fee increases by all physicians in the local area; all too frequently, Medicare would pay whatever fees were demanded.

Beginning in 1973, the Medicare Economic Index served as an upper limit on per-service reimbursement increases. But the MEI worked slowly -- between FY '77 and FY '85 physician expenditures still grew at an average annual rate of 19 percent. More recently Congress enacted a fee freeze (from 1984 to 1986) as part of the Deficit Reduction Act of 1984. Physician outlays increased by 10.5 percent between FY '85 and FY '86, when the freeze was in full effect. To a large extent, expenditures increased because the volume of services increased. Savings were lost as physicians responded to constrained fees with increased volume.[5]

Volume Remains The Problem In Changing Part B Incentives:

How we might restrain total physician and other SMI expenditures remains elusive. The volume of services per Medicare beneficiary continues to climb, approximately 6 percent every year, because the system allows, and perhaps even encourages, a "bill more, receive more" approach to medical reimbursement. Numerous studies of geographic variation in utilization of services have raised significant questions about the appropriateness of many of these services. The challenge to Medicare is how to establish

incentives for appropriate utilization and cost containment. Only when these incentives are apparent to providers and beneficiaries alike will long-term reform of the Medicare physician payment system be possible.

One widely discussed reform measure is the implementation of a physician fee schedule based on a relative value scale (RVS). The Administration is currently studying the RVS report by William Hsaio and his associates at Harvard University and look forward to the Physician Payment Review Commission's 1989 Annual Report. I will simply repeat what others have already suggested. Changing relative Medicare reimbursement amounts for procedures without slowing the growth rate in total reimbursements is not likely to lead to long-term reform.

FY '90 Part B Proposals Patterned on Past Congressional Action:

The Administration proposals to restrain the growth in Medicare Part B provider reimbursements per service (fees) are patterned on Congressional action taken in the past. For non-primary care services, the budget proposes a freeze for one year in the MEI, and then an increase of one percent per year in 1991 and 1992. For primary care services, the budget proposes to increase payments by the full MEI each year. The budget proposes a 12 percent reduction in payment levels for certain overpriced procedures, continuing an approach suggested by the Physician Payment Review Commission. Exclusive of the specific procedures identified as overpriced, the budget includes an 8 percent reduction in radiology, anesthesiology, and surgery services. While these proposals are important, immediate steps, they must be followed by longer-term, structural changes.

The Administration looks forward to working with Congress to achieve long-term reforms in physician reimbursements which would save money for both the taxpayers and Medicare beneficiaries without compromising the quality of the SMI program.

Medicare Hospital Spending -- Barely In Control:

In 1983, the Congress and the Administration implemented a fundamental reform in the way Medicare financed hospital inpatient services, by shifting from a cost-based, retrospective payment system, to a Diagnosis-Related Group (DRG) Prospective Payment System (PPS). Since then, the real growth rate in hospitals' costs per admission growth rate of Medicare's spending on

inpatient hospital services has moderated only slightly from the pre-PPS period. Over the 1967-1982 period, Medicare hospital payments per admission grew at a real average annual rate of 5.7 percent; over the 1983-1989 period, real growth in payments per admission averaged 2.5 percent.[6]

PPS -- while successful in encouraging hospitals to reduce excessive lengths of stay and inappropriate admissions, has yet to provide full incentives to hospitals to reduce costs per admission. In recent testimony, Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC), pointed out that "the hospital industry has not yet fully adjusted and adapted to the incentives of PPS." For example, Altman hypothesizes that hospitals may have "changed their strategy from reducing costs to expanding the services they provide to generate additional revenue."[7] Assuming renewed attention to PPS cost-reducing incentives, we can expect that as the hospital industry begins to adjust to PPS-imposed incentives, the average growth rate will remain moderate, rather than increase.

In non-PPS Part A spending, an upward trend in growth rates threatens the long-term viability of the Hospital Insurance Trust Fund. The introduction of PPS encouraged a shift both to out-of-hospital treatment locations, and to services which are paid on a cost-basis. Since PPS, non-hospital Part A spending has grown at an inflation-adjusted average annual rate of 6.3 percent.

Hospital Capital: Prospective Payment in FY '92:

A final area of Part A spending which demands attention is hospital costs that continue to be paid on a cost pass-through basis, of which capital costs represent the largest component. Capital will be paid prospectively, beginning in FY '92.

Until then, hospitals have a strong incentive to classify or shift costs from operating to capital. In general, under the capital cost-reimbursement "pass-through," Medicare pays its share of capital costs based on the proportion of Medicare patient days to total patient days in a hospital -- regardless of the occupancy level of the hospital. As the number of under-65 admissions and their lengths-of-stay have fallen, the ratio of Medicare utilization to total utilization rises, along with Medicare's share of hospitals' capital costs.

Average occupancy rates in the hospital industry are low, generally below 65 percent (chart attached). Even as hospital occupancy rates drop, more and more of Medicare expenditures finance hospital capital expansion. Between

1984 and 1994, capital costs as a percentage of total Medicare inpatient costs will increase from 8.9 percent to 12.2 percent.[9] In the long-run this will erode any progress made in slowing the growth of operating costs because, historically, increased capital costs drive up future operating costs.

The Administration's proposal on capital is to extend the current law level of 85 percent reimbursement. Given hospitals' low occupancy rates, a further 10 percent reduction is proposed. We recognize that paying for capital on a prospective basis will dramatically improve hospitals' incentives to invest prudently.

Proposed FY '90 Hospital Update -- Market Basket Minus 1.5:

When PPS was enacted, hospital payment rates were to be updated annually by the Secretary of Health and Human Services. Instead, the updates for FY '86 through FY '89 have been set by legislation, with each year's update being set below the Hospital Market Basket Increase (HMBI) increase. For FY '89 the Omnibus Budget Reconciliation Act of 1987 set the average PPS update factor at the HMBI minus 2.1 percentage points, for an average update of 3.3 percent.

For FY '90, the President proposes an update equal to the HMBI minus 1.5 percentage points. Compared to the full HMBI, the President's FY '90 Budget proposes a more generous update than the FY '89 Congressional adjustment of the HMBI minus 2.1.

To put the Administration's update proposal in context, it is important to acknowledge several features of Medicare hospital payment policy. First, as mentioned above, the Hospital Market Basket Index is only part of the complex calculation necessary to set a correct update. Several key variables must be applied, such as technology, productivity, potential for the introduction of greater efficiencies, service diversification, increases in case mix not associated with treating sicker patients, changing scale economies in the hospital industry, and changes in service delivery systems and practice patterns. Also, there must be incentives for continuing increases in productivity.

In addition to their regular payments, hospitals receive an additional $13 billion in payments for capital, direct and indirect medical education, disproportionate share costs, and cost and day outliers. The net effect of the 1984-1989 PPS updates coupled with these other payments was to provide hospitals with a 40 percent increase in payments per case -- 50 percent higher than the increase implied using only the update-derived increases.[10]

More important, the base upon which payment updates are made is seriously skewed. Since the PPS standard payment was based on data which overstated hospitals' costs, the annual updates have resulted in payment levels in excess of the level contemplated by the designers of PPS. A February 1989 Congressional Budget Office report to the Congress identified a $2.4 billion savings opportunity and stated:

> "[I]f the 1983 per case payments had grown each year by the change in the Medicare Hospital Market Basket Index plus two percentage points (to allow for increased complexity), payments in 1990 would be 6.5 percent lower" (than currently projected).[11]

Medicare Support of Graduate Medical Education:

Additional payments are made to teaching hospitals under PPS for the indirect costs attributable to graduate medical education programs. Teaching hospitals are thought to incur higher costs due to such factors as increased diagnostic testing, increased number of procedures, higher staffing ratios, and more complex record keeping. Medicare reimburses teaching facilities for these costs through an percentage adjustment to their regular PPS payments. The adjustment is based on the ratio of residents and interns to beds and an estimated factor representing the incremental patient-related costs of providing graduate medical training.

The Technical and Miscellaneous Revenue Act of 1988 set the adjustment factor at 7.65 percent for FY '89 through FY '95 and at 8.29 percent thereafter. There exists considerable evidence that this add-on is too high. The General Accounting Office and the Prospective Payment Assessment Commission (ProPAC) have both issued reports this year concluding that the add-on is excessive and recommending significant reductions.[12] GAO's analysis supports a rate of 6.26 percent, while ProPAC suggests a three-year phase-in of a 4.4 percent rate.

To restore equity in this add-on payment system by more accurately reflecting the real effect of teaching programs on average operating costs per case, the Administration's budget proposes a 4.05 percent adjustment starting in FY '90.

Medicare also subsidizes the direct medical education costs of teaching hospitals. Medicare makes special payments to hospitals for the reasonable direct costs of services furnished by interns and residents and appropriately allocated overhead. Approved direct medical education costs are excluded from the calculation of the PPS rates.

The budget proposes that graduate medical education payments are based only on the costs related to intern and residents salaries and salary-related fringe benefits, and appropriately allocated overhead. Non-Medicare related program costs such as classroom space and supervision by teaching physicians would not be reimbursed. Payment for these costs represents a subsidy for education rather than compensation for providing services to Medicare beneficiaries.

Direct medical education reimbursement for nursing and allied health professionals would not be affected by this proposal.

Conclusion:

In closing, Mr. Chairman, I want to re-emphasize that opportunities to invest in the Nation's future and create a kinder and gentler America depend on restoring domestic fiscal balance. Restraining the growth in Medicare is an essential step toward achieving this necessary balance, and I look forward to working with you and your colleagues on this matter.

Appendix: President Bush's Budget -- Medicare: Proposed "Savings" Relative to "Current Services"

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[1] Schieber, George J. and Poullier, Jean-Pierre, "International Health Spending and Utilization Trends," Health Affairs, Vol. 7, No. 4, Fall 1988, pp. 105-112.

[2] Health Care Financing Review, Summer 1987, "National health expenditures, 1986-2000," Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration.

[3] Schieber, George J. and Poullier, Jean-Pierre.

[4] U.S. Senate Special Committee on Aging, Aging America: Trends and Projections, 1987-88 Edition, p. 57.

[5] Preliminary data from Mitchell, et al., suggests that a large part of the savings anticipated from the fee freeze may have dissolved as the volume of physician services grew in response to the freeze.

[6] HCFA Budget Control Tables, adjusted by CPI deflator.

[7] Testimony of March 1, 1989 before the Subcommittee on Health, House Committee on Ways and Means.

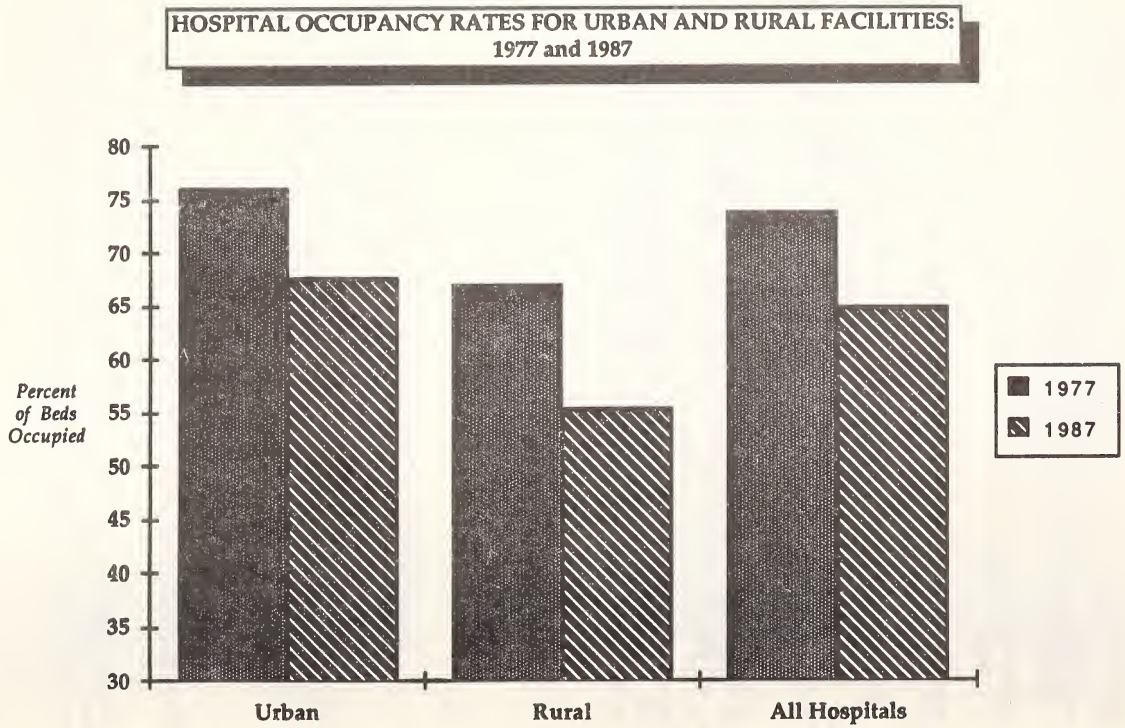
[8] American Hospital Association estimate for U.S. community hospitals.

[9] Health Care Financing Administration, Division of the Budget.

[10] Data from the September 30, 1988 PPS update notice in the Federal Register and from the House staff report entitled "Background Material and Data on Programs Within the Jurisdiciton of the (House) Ways and Means Committee," March, 1988.

[11] Pages 99-102 of the February 1989 CBO report to Congress entitled "Reducing the Deficit: Spending and Revenue Options."

[12] January, 1989 GAO report entitled "Indirect Medical Education Payments are Too High" and the March, 1989 ProPAC Annual Report to the Secretary of HHS (pages 69-74).



Source: American Hospital Association, National Hospital Panel Survey

Appendix

PRESIDENT BUSH'S BUDGET—MEDICARE: PROPOSED "SAVINGS" RELATIVE TO "CURRENT SERVICES" [1]

(Outlays in millions of dollars, net of offsetting receipts)

	1990	1991	1992	1993
Medicare Current Services	99,977	115,238	131,611	145,702
Extensions of Current Provisions				
Capital at 85% of Cost Allocation	930	1,190	1,300	1,420
25% Floor on Part B Premiums	714	1,757	2,812	4,409
Clinical Lab Limits	190	330	410	480
Continue Current Provisions	1,834	3,277	4,522	6,309
Further Restraint on Cost Growth				
Part A Proposals:				
Capital at 75% of Cost Allocation	620	780	880	940
Reduce Indirect Medical Education to 4.05%	1,020	1,290	1,410	1,540
Reduce Part A Graduate Medical Education Overhead	120	130	135	140
Update PPS Rates by Hospital Inflation minus 1.5%	625	800	875	955
Other Part A Proposals	10	21	23	25
Subtotal, Part A Proposals	2,395	3,021	3,323	3,600
Part B Proposals:				
Freeze Non-Primary Physician Prevailing Charges	375	960	1,640	2,085
Reduce Radiology, Anesthesia, and Surgical Payments by 8%	250	430	510	570
Reduce Payments for Overpriced Procedures	100	180	210	240
Target Physician Reforms	70	155	210	255
Limit Outpatient Department Reimbursements	0	220	520	780
Reform Durable Medical Equipment Payments	160	240	290	330
Eliminate Home Kidney Dialysis Loophole	50	100	150	230
Reduce Part B Graduate Medical Education Overhead	30	30	35	40
Impact on Part B Premiums	−295	−612	−876	−1,076
Subtotal, Part B Proposals	739	1,703	2,689	3,454
Interaction—Catastrophic Health Insurance	90	160	200	250
Total	5,058	8,161	10,734	13,613

NOTE: The budget also reproposes one Part A revenue proposal. Under current law, all State and local employees hired after March 31, 1986 are covered by HI. This proposal would extend coverage to all State and local employees and generates revenues of $1.8 billion in FY 1990.

[1] HCFA actuary estimates.

Chairman ROYBAL. Well, thank you, Mr. Darman.

I would like to start out the questioning particularly on your assumption that the full $5 billion cut will not affect beneficiaries, and then you also argue that if you had other things added to it, that eventually the cut would amount to $1.2 billion.

I suppose that one could go beyond that and start getting new initiatives that would maybe reduce that amount.

Now, we are talking about the facts as they exist today. Will a $5 billion cut benefit beneficiaries or will it not?

Mr. DARMAN. I think that it will have a slight adverse effect on beneficiaries, and I did not say that we would do this in a way that would have no adverse effect. I said what we should seek to do is to have, in effect, the minimum adverse effect, that some restraint on growth is bound to have some effect somewhere in the system that works its way through to beneficiaries.

We have tried to structure this so that the maximum effect is felt on providers, on hospitals and doctors, and not passed through to beneficiaries. But I do believe that a case could be made that there is, in effect, some pass through to beneficiaries ultimately.

Could I add one point, however? To the extent that the system is better kept under control, ultimately, the effect on beneficiaries, I would argue, would be favorable because the system is ultimately going to be able to provide more benefits for whatever level of resources the society is willing to spend. Over the longer term, one has to be worried about the financial viability of this system, and with that in view, the sooner we get about the business of restraining the growth of costs, the better off in the long term everybody would be.

Chairman ROYBAL. Yes, but you also argue that an increase to Medicare is a threat to other major objectives in any budget. The matter is that any increase in any department of the Federal Government would be a threat to other departments.

So, that is not an unusual situation with regard to Medicare. The truth of the matter is that our study shows that care costs have gone from less than 13 percent of income in 1980 to as much as 20 percent of income, projected in the year 1993.

In this particular study, we used a constant figure that was applied to Medicare and Medicaid and did not take into consideration the $5 billion cut.

If these statistics are correct, would you not agree that the $5 billion cut would definitely affect the beneficiaries in this instance and not, as you say, would have very little effect?

Mr. DARMAN. Mr. Chairman, I have not seen the study. I am familiar with an outline of it, but I have not actually—it came out today, correct?

Chairman ROYBAL. No, not today. We have had these figures and they have been released for quite a long time.

Mr. DARMAN. Oh. I thought you were referring to the study that was—

Chairman ROYBAL. Well, the study today also includes them.

Mr. DARMAN. Well, in any case,—

Chairman ROYBAL. This Committee has had these statistics before.

Mr. DARMAN. In any case, it is bound to be the case that if we can restrain the growth of costs of hospitals and doctors without changing the coverage for beneficiaries, the beneficiaries will over the long term be better off.

Chairman ROYBAL. What was your answer?

Mr. DARMAN. Over the long term, the beneficiaries will be better off if we can restrain the cost of the medical services.

Chairman ROYBAL. Well, the whole Nation, Mr. Darman, would be better off if we would restrain the cost of Federal spending.

Mr. DARMAN. That is what I am—

Chairman ROYBAL. So, the argument—

Mr. DARMAN. [continuing] currently paid to try to do. People do not much like it, but, unfortunately, I have to try to do it.

Chairman ROYBAL. Well, the truth of the matter is that because of time, we have a situation where it is costing more, costing the beneficiary more, and my question was, under the present state of affairs, would not a $5 billion cut further hamper—

Mr. DARMAN. No, not necessarily. No.

Chairman ROYBAL. That is what I cannot understand.

Mr. DARMAN. Because the beneficiary is getting the same services, at least hypothetically, exactly the same services as before. What has happened is that under these proposals, by and large, the hospitals are being reimbursed less than they would otherwise be, and doctors are being reimbursed less than they would otherwise be.

Chairman ROYBAL. But the beneficiary has to pay more?

Mr. DARMAN. The beneficiary only—only with respect to the supplementary medical insurance premium, and that, I think, is what you are referring to, and, there, we have a little bit of a difference of interpretation.

I would contend that all we are proposing is to extend the existing provision of law, the 25 percent floor. If you start by assuming that that is going to disappear, then when you turn around and put the provision back, well, yes, the beneficiary will be said to be paying more.

It is a small amount more, by the way, but it is under that particular heading, more.

Chairman ROYBAL. Well, it is not a small amount, Mr. Darman, to those individuals who are barely existing in this Nation, and there are pockets of poverty all over the United States.

My time is up, Mr. Darman. This matter has not been clarified, at least not in my opinion.

We now recognize Mr. Rinaldo for 5 minutes, so that he can ask his questions.

Mr. RINALDO. Thank you, Mr. Chairman, and thank you, Mr. Darman, for your testimony.

While we are very concerned about the rate of increase in all Medicare spending, the escalation in physician payments as was mentioned is especially troublesome.

C.B.O. estimates growth in excess of 20 percent for fiscal year 1990 for Part B alone, and as you know, over 70 percent of Part B reimbursements are made to physicians. The relative value scale study was just completed at Harvard, and DHHS is now preparing a report for Congress.

I wonder if you have had an opportunity yet to look at that work.

Mr. DARMAN. I have looked at the summary of the work, and you are correct that it is under analysis at HHS. I believe the analysis is required by law, but not until July, if my memory serves me correctly. In any case, it is not complete at the moment.

Mr. RINALDO. Do you think that this system offers any hope for beginning to bring physician reimbursements under control?

Mr. DARMAN. I will give you my own preliminary judgment, which really ought not to be taken as administration policy or position, but my view is that the system has some merit.

In fact, some of our changes are, in effect, changes in the relative value for one set of services rather than another, and this is a different way of going at it. But there is possibly a problem associated with it that I think we would all want to focus on more carefully, and that is whether, if you straightened out the relative values to the satisfaction of all reasonable neutral analysts, whether you would still have a problem in that people could game the system, not beneficiaries, but doctors, and increase utilization as a way to get around it, so that there would not be the savings one intended.

That, at least, is the heading under which I think careful analysis has to proceed in addition to looking at the relative values themselves.

Mr. RINALDO. Well, as I understand the President's budget, there are a number of options for saving $800 million in physician payments.

Now, CBO has estimated other options, such as a fee schedule or elimination of geographic inequities in physician payments.

Do you think these additional options are enough, and, if not, what is the administration's preferred long-term strategy for controlling Part B outlays?

Mr. DARMAN. I cannot tell you the answer to a preferred long-term strategy because every analysis that is undertaken under this heading that I have been associated with or known of always produces the second-best solution. Nobody is ever very happy with what they find, at least I am generally not very happy with what we find to be the answer any time we do a major long-term analysis of this.

I think there are inherent difficulties in the system which make it extremely difficult to come up with a satisfactory long-term solution.

With respect to the near-term and the need to readjust the payments for certain categories of physician service, and the need to restrain the growth generally, I think our proposals represent a reasonable and workable set. We are looking at the relative value scale alternatives. We are happy to look at other alternatives.

As we look at all of them, we have to also look at two related questions. One of them is the one I mentioned, the opportunity to game the system, and the second one relates to the question of when one is restraining the fees for doctors, there are not opportunities for doctors to pass the costs on to the beneficiaries.

Mr. RINALDO. All right. Thank you.

Chairman ROYBAL. Why do we not try to stick with the 5-minute rule, Mr. Darman?

Mr. DARMAN. I will try to be a little less verbose.

Chairman ROYBAL. So that as many as possible can get at least one question in?

The Chair now recognizes Ms. Oakar.

Ms. OAKAR. Thank you, Mr. Chairman.

Mr. Darman, thank you for appearing, and I am pleased with some relative restoration of funds in Medicaid.

Having said that, let me go into Medicare for a minute.

Basically, what you want to do is change the trend of the current law and projections which would demand a $10 billion increase, reduced $5 billion, which is really the net effect of which is a cut, which, as you know, we have seen about $35 billion with the cuts since the Reagan administration began its assault on Medicare.

I wonder if you could tell us, because you are talking about the growth of Medicare, do you know how many people turn 65 every day of the week in this country? Are there more recipients by any chance? Is that one of the factors involved?

Mr. DARMAN. I do not know how many turn 65 every day of the week. I am sure you must. I would be curious to know. What is the number?

Ms. OAKAR. 5,000 or more.

Mr. DARMAN. And they all vote.

Ms. OAKAR. Well, you know, putting it in that light, frankly, I think, well, I think it is to their credit because they are among the most patriotic in the country, among other things, and they are the reason we are the greatest country in the world.

So, you know, having said that, the fact is, do you know what the average check is, median income check, for an elderly woman over 65 who is the poorest in the country?

Mr. DARMAN. The poorest what?

Ms. OAKAR. Poorest person in the country is a woman over 65, and those are two-thirds of the people—

Mr. DARMAN. The average check from what? I do not know the answer.

Ms. OAKAR. Social Security.

Mr. DARMAN. No. What is it, roughly?

Ms. OAKAR. $400 a month.

Mr. DARMAN. I would have thought $500, but okay.

Ms. OAKAR. It is $400 a month.

I mention that because one out of $4 in addition to what they pay for the premium of Medicare, and, of course, your administration does not recommend a civil service cost of living adjustment and the average spousal benefit is under $6,000 a year. So, you really—you know, there are some other poor people outside of Social Security.

But I mention these kinds of statistics because you mentioned that we cannot allow Medicare to continue to grow. I mean, the fact of reality is that we have more older people. The fastest growing population are people over 85.

What about the growth in the Pentagon budget? I authored the transfer amendment in 1981 that transferred $4.6 billion from the Pentagon budget back to Medicare and that passed rather readily.

When I pointed out to the Members that the cost overruns in 1 year that were over 25 percent overrun in the Pentagon budget,

the computerized list, which the Pentagon gave me the day of my amendment, was over 14 feet long, which all I did was take the overrun of a helicopter project that was supposed to cost taxpayers $4 billion, ended up in 1 year costing them $8.6 billion. There was the transfer that we could have back.

Can I ask you, because you certainly do have responsibility over the entire budget, and it is an awesome job, but have you looked into the question of overruns in the Pentagon budget and the growth in that area that seems to not demand a quality defense, but certainly an expansion for filling the pockets of people that are overcharging the taxpayers of this country?

Mr. DARMAN. Yes. Could I make a couple of quick points?

Ms. OAKAR. Sure: What are you doing about it?

Mr. DARMAN. Because you raised several questions, and I do not want to consume too much time.

One, on the population growth of older Americans, yes, it is a serious issue. We should be happy that we are all living so much longer and so on and so on and so on, but 2 percent of the growth of Medicare expenditures, roughly, can be accounted for by—of the percentage growth, 2 percent is due to population growth.

The largest contribution—

Ms. OAKAR. According to whom?

Mr. DARMAN. According to the Medicare actuaries.

The largest portion of the growth is in the growth of the physician charges. The largest portion is not in the growth of the population.

Ms. OAKAR. Let me just say that my time is expiring, and I would question your actuaries, but let me tell you something.

We have put restraints on physicians, on hospitals, and everybody else. You know, I know, everybody in this room knows that when you demand that hefty of a cut, you are affecting the life blood and survival of these older people.

I mean, that is the bottom line.

Mr. DARMAN. Could I mention—

Ms. OAKAR. They cannot afford it. They are going to be the ones to pay for it, and I think you ought to take it out of some of these overruns in the weapons.

Mr. DARMAN. Well, after I left the Cabinet Committee on Aging and went to the Defense Department in 1972-1973, and that is what I used to work on, and now that I have come to OMB, we have started a major study to try to get that problem under control, too. As you may have read in the newspaper, I am generally accused of having been someone who was pushing for the restrained growth in Defense, and the decision to cut from the Reagan growth by $44 billion over 4 years, which is reflected in the Bush budget.

I am responsible for pushing in that direction. I do believe restraint has to come under all headings, but I also believe that that must include Medicare. I said in my opening statement that I thought that restraint has to be balanced, and I take it that is also your point, and we are trying under all headings.

I can assure you that I am at least as unpopular with the Defense Department as with those who are interested in expanding Medicare.

Chairman ROYBAL. Time has expired.

The Chair recognizes Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

Mr. Darman, I have read your statement. It is an excellent summary of the situation, and outlines very clearly some of the difficulties ahead that confront us.

I have a couple of questions. Do you think we should give some consideration to rebasing the prospective payment system? There seems to be inequities across the country because of it.

Mr. DARMAN. We have not proposed that, as you know, and CBO, I am just told, estimates that it would save as much as $2.1 billion.

I have looked over the CBO list, and we have told the Ways and Means and Finance Committees that we would like to look at the CBO options in addition to our own in the course of developing legislation under this heading, and we will be doing that.

But at least to this point, we have not endorsed that proposal. CBO, I just might note, as I know you know well, CBO has suggested that beyond the $5 billion, there could be over $6 billion in savings without having sharp cuts or adverse effects on beneficiaries.

Mr. REGULA. Well, I think the GAO has given some support to it, and I have asked them to elaborate on their opinion.

The situation for rural hospitals is particularly severe; mostly because of financial problems, size and so on.

Do you think there is anything that can be done or do you contemplate some way to address the problem of the smaller units?

Mr. DARMAN. Well, I am aware of the problem and the argument about the problem, and I would not wish to say that we were totally inflexible on the subject. I think it has to be looked at on the merits as to whether there does need to be some special adjustment for selected rural cases or for the rural versus urban split.

That is not in our proposal as you know, but given the special situation of some rural hospitals, I do think we have to look at it carefully.

Mr. REGULA. My last question is the President has indicated that the current mother and child health care in the fight against infant mortality are high priorities, and yet there appears to be no Federal funds in this budget for expanding in those areas.

What do you contemplate to meet the President's position in terms of funding?

Mr. DARMAN. Well, there is a proposal, as you know, to expand the mandatory coverage under Medicaid, but the total funds do not increase relative to current services because we have an offsetting reduction in the reimbursement for selected administrative expenses, primarily the match rate on computers which was set up in a period when States had not yet, or at least it was thought they had not yet, understood the full benefit of automatic data processing, and that we should give them a special incentive to do so.

It is argued, I think correctly, that they appreciate that benefit and no longer need the special incentive and that we can offset the increases with that administrative saving.

That is why the dollar number does not increase, though the benefits do.

Chairman ROYBAL. Now, Mr. Derrick.

Mr. DERRICK. Thank you, Mr. Chairman.

Let me repeat a question that Mr. Regula asked you, and if I may be so bold as to say so, I do not think you answered it.

On the rural hospitals, I have 13 hospitals in my district. A large number of them are rural. Some of them are urban.

With the exception of two hospitals, one a private hospital and the other that has a strong endowment, I do not see that they can stay in business much longer without some sort of adequate reimbursement.

What I want to know is what you plan to do, and I also want to know is there a determined effort with you people to do away with rural hospitals. It appears to me that it is.

Mr. DARMAN. No, sir. It certainly is not. I cannot imagine how or why someone would wish to have a concerted effort to—

Mr. DERRICK. Do you know if it swims and it quacks, you have a right to assume it is a duck.

Mr. DARMAN. Well, obviously, it is not fair to characterize rural America as if it is some single entity. There are, as you well know, probably better than I do, wide variations in what really is going on in different parts of rural America, but some parts of rural America are losing population for reasons that have absolutely nothing to do with the Medicare program, and—

Mr. DERRICK. With all due respect, I know what the problem is. What I would like to get—

Mr. DARMAN. I was trying to get at those, sir. If the reason that a hospital is in trouble is that the area itself is declining, the solution is not a Medicare solution. The solution is a solution under an entirely different heading, perhaps, that has to do with what our society's attitude is with respect to rural development.

Mr. DERRICK. Let me give you an example of one hospital that I am familiar with that is in a growing area, not a declining area, that is an $80 million hospital, and they lost about $22 million last year on Medicare, on failure of Medicare reimbursement, and, you know, they can pick up a little here and a little there out of the private patients, but they cannot do that over the long period, and what it is, it boils down to, is absolutely that our government has overpromised and underdelivered on this Medicare business.

Mr. DARMAN. Well, Congressman, that is not—

Mr. DERRICK. And here, you know, the administration is knocking another $5 billion out. I mean, it just sounds absurd to me.

Mr. DARMAN. I do not want to go over old ground, but I do not believe that we are knocking another $5 billion out. I think that a good portion of that is—let me see—almost a billion of it is just keeping the capital reimbursement level at its current 85 percent, and the question, I guess, is whether for that particular hospital, that is adequate.

I do not know the facts on that hospital, but the numbers you cite are not consistent with the overall averages that I have seen.

Mr. DERRICK. Well, they are fairly consistent in my district, taking the urban and the rural hospitals. The rural hospitals are a little harder hit than the urban, but, you know, quite frankly, they are all going to be out of business here in a few years at this rate, and what they point to primarily, and I have looked at the books, is the failure of Medicare reimbursement and here we are knocking $5 billion out of the budget, and it just does not make sense.

Chairman ROYBAL. The time of the gentleman has expired.

The Chair now recognizes Mr. Fawell.

Mr. DERRICK. You can answer me later.

Mr. FAWELL. Thank you, Mr. Chairman.

Mr. Darman, I want to express my thanks for your thankless task, I think, in which you are involved in undertaking efforts to restrain spending, which is never very easy.

I appreciate your explanation in regard to cuts being cuts of increases and not cuts as often the case, and when I have my town hall hearings, often times, I do try to bring this out to my senior citizen constituents, that let us understand that, and we do have, I think, a fairer comprehension of it all.

I do appreciate your breaking down that $5 billion cut, and that has certainly helped me.

The one question I would have to present to you is, in terms of long-term growth, we have—I do not know if anybody has an answer to the short-term explenential explosion of the cost of delivery of health care services, but let me refer you to the Medicare Catastrophic Protection Act. I do not think that is the technical new title as that bill was finally passed, but in terms of—a number of us in Congress, including myself, feel as though Congress did not do the best job in passing that legislation, and it is estimated that $31 billion just to phase in the costs of that new program over the first 5 years is what the tab will be.

H.C.F.A. already indicates, has indicated in several news articles, that there will be a $4 to $5 billion shortfall just in the out-patient prescription drug program, and knowing Congress notoriously underestimates, as we did when we created Medicare, we said it would be about $8 billion out of cost in 1990, and we are about $90 billion off that, could I have your thoughts about—is this going to just exacerbate this tremendous growth we have in Medicare services and what, if anything, does the administration plan to do?

Mr. DARMAN. I thank you, Congressman, for your comments and for the question.

As you know, the catastrophic provisions are new, and in the course of the election campaign, then candidate Vice President Bush did come out in favor, as the Reagan administration did, in favor of the catastrophic insurance bill as it ultimately came out of the Congress and was signed by the President.

We are not changing our position on that. We do not believe that the bill should be reopened at this time or in the foreseeable future. It is new. We ought to continue to work on the estimates.

On the drug issue, we did not initially support that, as you know, nor, I think, did the House initially. It came in on the Senate side, and at OMB, we did estimate that the costs of that would be substantially higher than some others had estimated, and if those higher costs were right, there would be a long-term funding problem. But we have got further analysis to do on those cost estimates, and at this point are definitely not suggesting that we should reopen that issue.

Chairman ROYBAL. Time of the gentleman has expired.

The Chair now recognizes Mr. Vento.

Mr. VENTO. Thank you, Mr. Chairman.

Mr. Darman, the Part A Fund which we have been talking about sustains a significant number of the costs from current service budget. They are real costs. I mean, they are going to be absorbed, whether you—I mean, I understand your concern about holding costs down, which we are talking about at the moment, but that Part A budget, trust fund, is in surplus.

It is, of course, on a current services basis, and, so, the basis is we are going to take that money and use it for Part B or for some other purpose, is that correct?

Mr. DARMAN. Not necessarily. I mean, the money—from the standpoint of consolidated—

Mr. VENTO. What is the amount of surplus for fiscal year 1990? How many billions of dollars in surplus is the fund? Part A?

Mr. DARMAN. I do not have the surplus at the moment handy, but it is supposed to be bankrupt under the actuary's estimate by early in the 21st Century.

Mr. VENTO. In the 21st Century. In the current services budget, there would be a lot of things that will be bankrupt by the 21st Century. Some are even bankrupt right now, like the S&Ls, I guess, but that is—I mean, the point is—

Mr. DARMAN. That is exactly why we have to restrain the growth in some things.

Mr. VENTO. [continuing] it is a pay as you go system. I mean, I do not disagree with that, but I am just saying there is a surplus in terms of the 1990 account, is that correct?

Mr. DARMAN. There is a surplus in 1990. I just do not know what the amount is, but—

Mr. VENTO. No. I mean, it is in the range of $3 or $4 billion. I do not have it in front of me. I am just trying to point out that in Part A.

Now, in Part B, of course, you make a contribution of some $35 or $40 billion. I mean, that is important to note, and that may have been a better response, but you did not give me that one.

But the fact is, when you talk about holding costs down, health care costs down in terms of this, you are not holding down the costs for anyone but the government, in essence, are you?

You are holding down what we pay in terms of Part A or Part B. You are not holding down the copayments, are you?

Mr. DARMAN. No.

Mr. VENTO. Are you proposing that we hold down the copayments?

Mr. DARMAN. You mean as a percentage? It is not held down. To the extent—

Mr. VENTO. Well, the point is that health care costs are not reined in by virtue of this particular policy path. They have not been. You just talked about the failure of them for the last years during the period of time, and, so, the copayments have increased.

I mean, what we are saying to the senior citizens is, in essence, with a policy like this, is we are going to chop out $5 billion. We are going to save the money. You are on your own in terms of dealing with the hospital or doctor or medical bureaucracy, and I would tell you, Mr. Darman, that is what is happening. That has been the phenomena, whether or not you personally or I, and as a public policy initiative, that has been what the effect is, and I will tell you

that the people in my district and across this country are madder than hell about it.

Mr. DARMAN. Well, I tried to suggest that we are silent in the Bush proposals on this issue, which are the same as the Reagan proposals, on the question of how to assure that the beneficiary does not get hit with balance billing and extra charges. We have said that we would want to take another look at that.

It is an important—

Mr. VENTO. I appreciate that, and I just think we have to have some substance to it. I think we have been hearing that same song and dance for about 7 or 8 years around here, and the end result has been, as we both, I think, have observed, negative in terms of how it affects older Americans, to say nothing, of course, about the old catastrophic program and the responsibility and burden that older Americans have taken on there.

You know, I voted for it. I think it was appropriated. You know, we are sending the bill to grandma and grandpa there. That is all right, but I think at the same time, we have to look at that and what we ought to be doing here in terms of taking some actions because I think this idea of just saying, well, you know, we are just going to cut this and let the chips fall where they may is not acceptable on my part or on your part.

Mr. DARMAN. I am not trying to say that, Congressman. I have been taking pains to say that we submitted the Reagan proposals. We are happy to look at additional possibilities. Both with respect, I said today, to the issue of urban versus rural, and the issue of whether or not the beneficiary is adequately protected, as we attempt to restrain the growth on doctors.

If what you are seeking, however, is a much more fundamental reform in the system, I think everybody I know, who is serious about this, believes there has to be much more fundamental reform, but no one seems to be able to agree on what the satisfactory fundamental reform proposals would be. And that has been true at least for 20 years, and I suspect it is going to be true for as long as I am at OMB and quite a bit beyond that.

I am not saying we should not try, I am just saying being realistic, we have got to have restraints on the existing system for the near term, and if we can—

Mr. VENTO. Well, I just want to point out that the restraints are really one side. The restraints come in terms of dollars we spend. It is not a restraint on the cost to the individuals that have had the increase in copayments and, of course, the substantial increase in their various Part B premiums.

Thank you, Mr. Chairman.

Chairman ROYBAL. Thank you, Mr. Vento.

The Chair now recognizes Ms. Morella.

Ms. MORELLA. Thank you, Mr. Chairman, for calling this meeting on the important issue of the Medicare and Medicaid budgets.

Mr. Darman, good to see you. I think the President was wise to hire you because of your expertise, and I appreciate that.

I have a number of concerns, but, very briefly, one of them has to do with what is happening with the assistance that has been given to these teaching hospitals.

My understanding is that the assistance they were given really came from the PPS legislation in 1983, and that the reduction that is now being contemplated is even a greater reduction than what ProPac has suggested.

I would guess that common sense would dictate that these teaching hospitals very often handle the sicker people because they have the mechanisms for testing and other procedures. I am concerned, and I wanted to get your views on it regarding the effect this will have on the provision of health care for our sicker citizenry and what it will do for the teaching hospitals themselves that are already having great problems.

In your statement, you mention that it is to supplement education. It is not really. I realize that it is a difficult thing to justify by saying we are helping education alone. I do not see it that way. I see it really as helping the people. I am curious about the ramifications.

Mr. DARMAN. Thank you, Congresswoman, and thank you for your kind remarks.

First of all, there is, I think, what you might think of as a philosophical or policy issue on the extent to which Medicare itself should be used to subsidize teaching. But as you have suggested, let us put that issue aside.

I would note that our proposal involves savings under this heading of over a billion dollars. So, it is not a small matter. You are right. We are proposing that the indirect medical education payment drop from 7.7 percent to 4.05, and I believe you are also correct that ProPac suggests that it go down toward the same number, 4.4, I think, but that it do so over 3 years, not in one steep step And GAO, I believe, has suggested that the fair reimbursement level under this heading would be something like 5.1 percent.

So, we, ProPac and GAO, all seem to agree that it is in the range of 4 to 5 percent that is appropriate, and the difference is how fast you get from the 7.7 to there, but I do not think that there is any of the independent analysts who have concluded that the 7.7 number is the correct number analytically. They all seem to agree that it is closer to 4.

Chairman ROYBAL. The time of the gentlewoman has expired.

Ms. MORELLA. I would think this would be rather perilous and something we should look into further, too.

Thank you. Thank you, Mr. Chairman.

Chairman ROYBAL. All right. The Chair now recognizes Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Darman, when I was listening to your testimony, it seemed that you were saying that we need to save money, and, so, this is the $5 billion that we are going to save in the Medicare program, but at the same time, you seem to suggest that that was not going to mean necessarily a cutback in terms of quality of care or access.

The problem I have, the complaints I constantly hear in New Jersey, and I guess it is nationwide, is that the hospitals right now, be they public or private, just cannot meet their expenses, and that when they are trying to save money because of what is happening with government action, it means that they have to do less and that the quality of care suffers.

In addition to that, in New Jersey, we increasingly have a problem with physicians that do not participate in Medicare or do not accept assignment.

So, I guess my question is twofold. On the one hand, it would seem to me, and I would like a comment from you on whether or not you assumed that the quality of care in hospitals will decrease because of the government action, and, secondly, how we can continue to have access for senior citizens as physicians increasingly refuse to participate.

Mr. DARMAN. Thank you, Congressman.

Well, first of all, I will just quickly note that I do plead guilty to suggesting that we need to save money. I thought almost all of us agreed on that and the question is how that burden of restraint to be borne.

I do believe that the proposals we have offered have merit, that they are not arbitrary. As, for example, the last suggestion. It is not just OMB or the administration. GAO and ProPac seem to agree that it is analytically appropriate that there be some restraint with respect to indirect medical education and that is a billion dollars.

And as I have suggested, also, of the $5 billion, $1.8 is nothing but extension of existing provisions, and I do not really see, per se, why we should assume that extending the existing provisions will have a significant adverse effect on the quality of care.

Now, with respect to the remaining provisions, I do think that we have to look at those extremely carefully from two standpoints, especially.

One, are there selected kinds of hospitals that would be peculiarly adversely affected where we would not want to have that adverse effect, and, two, is there a better way to design what we have come up with? I think we should be open to looking at that, and we have said that we would be. The second question that you raised, correctly, I believe, is what about the ability of physicians to just pass on—who are not participating, to just pass on the increased costs to patients under another heading? There, too, I have said I do think we have got to take a further look at proposals to deal with that problem.

There are, of course, proposals available. It is just that the administration has not previously endorsed them, but I have said that we would look at them.

Mr. PALLONE. See, my problem is that I understand that we have to save money. I mean, everybody agrees with that, but I think the bottom line is that there is a direct result in terms of these cuts, in terms of quality of care at hospitals, and also in terms of the amount of participation in Medicare for those that accept assignment.

I think there is indeed a direct relationship, and I do not know how you can get around it.

Mr. DARMAN. Well, some of it, some of the relationship as reflected under these proposals, I would contend, if they were correctly designed, and allowing that we want them to be correctly designed, would be in reduced income for some doctors, not in a change in the world from the standpoint of beneficiaries. Meaning no disre-

spect to doctors, surely we would agree that some restraint is possible on the growth of income for doctors.

Chairman ROYBAL. All right. Time of the gentleman has expired.

The Chair recognizes Ms. Meyers.

Ms. MEYERS. Thank you, Mr. Chairman.

The reason that I made the point about the fact that this is really a $10 billion increase and not actually a $5 billion cut is not a quarrel with Medicare. I am very supportive of Medicare. My quarrel is with the baseline budget, which I think is terribly confusing to the American people, and obviously we have to look at all programs.

I mean, four programs make up about 73 percent of the budget in this country and that is defense, which is about 28, Social Security, about 22, that is half of the budget right there, about 14 to 15 percent is interest on the debt, and now about 9 percent is Medicare. Those are the big four.

Defense, Social Security, interest on the debt and Medicare make up 72 to 73 percent of the budget, and everything else you can think of is in that remaining 28 percent. Obviously, you have to look at it.

I would like to ask a question relating to the catastrophic program. I have had insurance people say to me, Mr. Darman, that without the catastrophic health program that we passed last year, that there may be or there may have been some kind of a crisis with the ability of older people to pay for medigap.

In other words, that the medigap was going to increase so substantially that it would have been a real problem for older people to pay for that, and then also that there may be a crisis or have been a crisis that we averted because the company plans that provide for retirees were actuarially set up and funded at a time when health care costs were so much lower and there were many fewer older people, so that a lot of those company plans that people are really depending on may not be able to deliver what they promise.

I really debated about whether to vote for catastrophic, but given that set of circumstances, I did vote for it, and I would like you to comment on that.

Mr. DARMAN. On the question of whether there were these crises that were thus averted by the enactment of the legislation, I am not as knowledgeable on that as I should be perhaps.

I do not know whether there would have been a crisis under medigap. I really ought to give you a more informed answer in writing after I have gotten better acquainted with the research. It would seem to me that it might well be true because the existing provisions, in effect, are a subsidy by wealthier premium payers of less wealthy premium payers for catastrophic. I would have thought that the less wealthy premium payers clearly are getting an advantage under this relative to what they would have had in the private marketplace.

Whether they would have been in crisis or not in the private marketplace, absent this, I just do not know enough about.

[The following information was subsequently supplied for the record by Mr. Darman.]

Based on a review of reports issued just prior to enactment of the Medicare Catastrophic Coverage Act of 1988, OMB does not believe a "crisis" existed in the medigap industry.

In his 1986 report on catastrophic illness expenses, then Health and Human Services (HHS) Secretary Bowen considered an expanded medigap industry as a possible solution to the "catastrophic expense" problem. While ultimately rejecting this solution, Secretary Bowen indicated medigap insurers would continue to fulfill an important role in a restructured Medicare program. The report made no reference to an imminent crisis.

In its 1986 report to Congress (GAO/HRD-87-8) the General Accounting Office did not find a medigap industry in "crisis". Instead, GAO concluded that current laws and regulations were effectively protecting the elderly against substandard policies.

Ms. MEYERS. I noticed that the Federal Accounting Standards Board issued a rule about a month ago that did say that companies in the future will have to print in their annual reports—

Mr. DARMAN. Right.

Ms. MEYERS. [continuing] the amount of money that they are setting out or setting aside to care for their retirees' health,—

Mr. DARMAN. Right.

Ms. MEYERS. [continuing] which seems to me to indicate that maybe there might be some concern there that some companies are not adequately funded to pay for all the health care needs if you also include catastrophic.

Now, with the catastrophic now coming under the government program, maybe that will not be such a problem.

Mr. DARMAN. That is a problem with which I have only some familiarity, especially in the case of the steel industry, where, as you know, a lot of the pension and health benefit plans were seriously underfunded, and the new accounting provisions will force that to be revealed, and that is a good thing, but the extent to which the problem is really a widespread and serious problem, I do not know enough about the data.

I would have been surprised to think that it is a big problem that would rise to the level of crisis. I think it was correctly viewed as such for a few companies, big companies, in industries that were in big trouble, but I do not think it is a systemic problem.

Ms. MEYERS. I would appreciate your responding to that for the record.

Chairman ROYBAL. Time has expired.

Mr. DARMAN. Yes, I will try to do so.

[The following material was subsequently supplied for the record by Mr. Darman.]

Double-digit medical cost increases threaten the solvency of health insurance programs. OMB is not aware of any unique threat to employer provided retiree plans.

Incorporating the new FASB standards could cost employers billions of dollars. The annual expense to firms will vary widely depending on the ratio of active to retired workers and on the nature of the existing benefit structure. The new standards could affect the willingness of some firms to offer retiree benefits.

Chairman ROYBAL. Mr. Darman unfortunately has to leave to attend a cabinet meeting scheduled to start at 2 p.m. His request was to leave no later than a quarter of two. We also have a call of the House, a vote that has to be made within 10 minutes.

So, we are faced with quite a dilemma. There are four more Members that wish to ask questions.

Supposing we do this, Mr. Darman. We give each 1 one minute, let them ask a question, you answer within that 1 minute, and I

think in that way, we can all make it, and we will all be reported as having asked a question.

The Chair now recognizes Mr. Manton. I know it is difficult, but under the circumstances, we cannot do any better.

Mr. MANTON. I have a brief question.

The President's budget proposal calls for increases in Medicaid, funding for programs for poor children and young mothers. Of course, this is a good idea. We all subscribe to that.

Question is, what will be the effect of these increases in funding for children and young mothers? Where is the funding going to come from if we do not have any increase in overall funding? Will it come from senior programs?

Mr. DARMAN. No. It comes from a reduction in the Federal match rate for certain administrative expenses that I alluded to earlier. The special match rates, ranging from 75 percent to 100 percent for certain administrative costs, primarily the use of computer systems, are especially high.

So, it is funded within the Medicaid program as we see it, but not coming out of benefits. It is coming out of the reimbursement for that set of administrative expenses.

Chairman ROYBAL. Ms. Unsoeld is recognized. Ms. Unsoeld?

Ms. UNSOELD. It appears to me that the administration is trying to look at the big picture in the long term, that somehow in these proposals, the whole system will be made healthier in the long run if certain restraints are imposed.

Now, under that kind of rational, would it not make sense to put a whopping increase into some of the cost effective preventive programs, such as WIC, Head Start, school lunch programs, education, long-term home health care? Is that not in the long run going to bring down the deficit and the cost of health care?

Mr. DARMAN. Thank you very much, Congresswoman.

I have to say I am delighted you asked that question because until this moment, it has been at times awkward, but happily we are proposing to increase spending for school lunches substantially, and as you may know, we undid a proposal that President Reagan had to cut the school lunch program.

We are also proposing to increase WIC, not enormously, $80 some odd million, and we are proposing an increase in Head Start by $250 million, and I am pleased to note that I believe the House just passed an increase in the Head Start authorization in exactly the amount that we requested.

So, under at least one heading, we might maybe get credit for doing something right.

Chairman ROYBAL. Time of the gentlewoman has expired.

The Chair recognizes Mr. Staggers.

Mr. STAGGERS. Mr. Chairman, I would ask unanimous consent that we be allowed to submit written questions for Mr. Darman.

Chairman ROYBAL. Without objection, that will be the order, and written questions will be submitted to you, Mr. Darman, and we sincerely hope that you will answer those questions as soon as possible.

Mr. STAGGERS. I do have a question, though, if I could reclaim my time.

Chairman ROYBAL. Will you proceed? You have 1 minute.

Mr. STAGGERS. Mr. Darman, I wanted to make three observations. You say you will look at the inequity in rural hospitals and urban hospitals. Hopefully, that means you will propose the equity be put into the reimbursement system.

Also, I think that looking at the VA system, keeping it a viable system, would help with Medicare funding, and also home health care, I think, saves money as opposed to costing money.

My question to you is, why not treat doctors like we are treating hospitals with DRG?

Mr. DARMAN. Well, as I suggested earlier, that is not the approach that we have taken exactly. I am not convinced the approach we have taken is exactly correct. I am not convinced that doing it on the DRG system would be exactly correct, or whether the relative value system is exactly correct.

None of these systems strikes me as adequately getting at what we really need to get at, but, on the other hand we have got to do something to restrain the growth of costs.

The problem is there are good arguments against each of these approaches and there are ways to game each of these systems that result in our not achieving the cost savings one would like to achieve, and yet the process of trying to define the better mouse trap is one that has escaped everybody for a long time.

Chairman ROYBAL. Time of the gentleman has expired.

The Chair recognizes Mr. Kennedy.

Mr. KENNEDY. Thank you very much, Mr. Chairman.

Obviously, I think just following up on Bruce Vento's comments, that we are really looking at not just cutting the fat but really cutting the meat at this point.

In the city of Boston, in the area that I represent, we have seven teaching hospitals that last quarter lost over $24 million under Medicare reimbursements alone. Those teaching hospitals, Mr. Darman, are going to be responsible for the indirect medical education, the capital payments and the reductions in hospital market basket, which are all the cuts in your budget, and I would just suggest, when all is said and done, there are going to be a lot of poor people that are really going to be hurt badly.

The hospitals themselves have been an easy political target for many politicians over the last 10 years. They are cut now to a point where they just are not going to provide the services.

We can argue about no new taxes, but the fact is that we are at a point where cutting $5 billion to appeal to the American people is just really hurting a great deal of vulnerable Americans, and I just think it is wrong, and I think we are going to hurt the hospitals and hurt the system without putting some more money into the system at this point.

Please be concerned about the teaching hospitals.

Thank you.

Mr. DARMAN. Thank you.

Chairman ROYBAL. Thank you, Mr. Kennedy.

Mr. Darman, we know what the situation is. I would like to continue this hearing, particularly get your views with regard to the administration's position. I do not think we have been able to accomplish that up to this moment.

We will be submitting questions to you in writing. I will do likewise, but the one question that I hope you can answer as soon as possible is the one that keeps on bothering me.

How can a reduction of $5 billion benefit the beneficiaries?

Mr. DARMAN. I did not assert, sir, that it benefits the beneficiaries. Certainly not in the near term. I cannot answer the question in a way that will support a proposition that I do not advance.

Chairman ROYBAL. But you—

Mr. DARMAN. I said that what we have to do is try to design it so it has minimum adverse effect on beneficiaries.

Chairman ROYBAL. Sure, but you also said that it would not hurt beneficiaries. I think you used that direct—whatever the situation is.

Mr. DARMAN. Yes, sir. I will try to give you a detailed answer on that and it divides into two headings, short-term and long-term.

Chairman ROYBAL. All right.

[The following information was subsequently submitted for the record by Mr. Darman.]

Question: How can a reduction of $5 billion benefit the beneficiaries?

Answer:
Since 1965, when Medicare was created, health care has consumed an increasing proportion of the Gross National Product, nearly doubling from 6.0% in 1965 to 11.1% in 1986. Similarly, Medicare spending consumes a large and rapidly growing portion of the Federal budget. As a society we can no longer afford to sustain the current rates of increase in either Medicare or national health care spending. The President's budget proposals are a starting point for restraint. If health care growth can be slowed, Medicare beneficiaries will be served well.

The Administration proposes extending the current floor on SMI premiums at 25% of program costs, a provision which is set to expire with the 1989 premium. Since SMI outlays are growing at an annual rate of 15%, monthly beneficiary premiums for 1990 will rise $1.40 more under this proposal. This is the only proposal which, in the short term, would affect all beneficiaries' costs. In the long term, beneficiary interest in controlling Medicare costs will help contain the growth in program expenditures.

The remaining Administration proposals would slow the growth in Medicare payments to providers, resulting in $4.6 billion in FY 1990 savings. These changes were designed to have minimum adverse effects on beneficiaries.

Approximately $800 million of the savings would be achieved by adjusting payments for physicians, reducing reimbursements for selected overpriced services and maintaining non-primary care physician reimbursements in 1990 at the 1989 levels. In the short-term and in the long-term these proposals would reduce or restrain beneficiary copayments. These copayments are set at 20% of the Medicare reimbursement. The reforms would also constrain the growth in beneficiary premiums. Medicare beneficiary access would not be changed by these proposals. Since physicians are constrained by the Maximum Allowable Actual Charge restrictions, beneficiaries are protected from excessive extra billing.

The President's FY 1990 Budget proposals for Medicare Hospital Insurance--which total $3.3 billion in savings--primarily focus on an extension and reduction to the current law provision for capital reimbursement, reforms to bring indirect medical education payments more in line with the actual costs of teaching hospitals, and correcting the excesses in the historically generous hospital payment update. None of these hospital proposals would adversely affect Medicare beneficiaries.

Mr. DARMAN. Long-term, I have a better ability to defend a case. Short-term, we can say that it is minimal adverse effect. I do not think we can say there is no adverse effect.

Chairman ROYBAL. Well, minimal means very little, I suppose, does it not?

Mr. DARMAN. Yes.

Chairman ROYBAL. All right. We do not agree with you, but let us get your answer to that question. We will submit other questions, and then maybe some time later, if everything is in order, we might have you back all by yourself for a question and answer period that would enlighten this Committee with regard to the administration's position.

I think perhaps that can be done, but somehow I think that as we go along, we will be further enlightened in other Committees. I will gladly welcome you when you come before our Committee on Appropriations. At that time, we will be dealing with another subject matter, but still dealing with the budget in general. We will ask you questions on that.

May I thank you, Mr. Darman, for your presence and for your testimony.

Mr. DARMAN. Thank you.

Chairman ROYBAL. This Committee will be in recess then until we all vote. We still have a panel of three more witnesses that we will be listening to. We hope that we will have more time for questioning than we had at this session.

Mr. DARMAN. Thank you very much, Mr. Chairman. I look forward to seeing you again soon.

Chairman ROYBAL. Thank you, sir.

The Committee is now in recess.

[Recess.]

Chairman ROYBAL. The Committee would like to call the witnesses to come and take their respective seats so that we can proceed.

Margaret Dixon, Kay Johnson, and Thomas Chapman.

Ms. Dixon is the National Board Member of the American Association of Retired Persons and will address the impact of past and present Medicare cuts on beneficiaries.

The Chair will recognize now Ms. Dixon.

STATEMENT OF MARGARET A. DIXON, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Ms. DIXON. Thank you, Mr. Chairman. My name is Margaret Dixon, and I am a Member of the Board of Directors of the American Association of Retired Persons. I am accompanied here today by Stephanie Kennan of our Federal Affairs Staff.

Our written statement outlines several areas of concern about the administration's budget proposals, but for the purposes of my oral statement, I will focus only on the Medicare budget proposals.

To begin with, AARP recognizes that Medicare will once again be subject to budget cuts. Our concern is the extent and the nature of those cuts.

In Medicare Part A, which pays for hospital care, the solvency of the health insurance trust fund is much improved. We should re-

member that only a few years ago, it was projected to be insolvent by 1987. It is now projected to be solvent until past the turn of the century, but continued close oversight will be necessary to ensure that Part A remains solvent.

Part A has borne the greater portion of recent Medicare budget cuts. Moreover, Medicare's prospective payment system has helped contain costs while still providing access to care.

AARP believes that Medicare should not guarantee providers a certain return on investment; rather, it is our policy that Medicare rates should be sufficient on average to compensate providers fairly.

Second, AARP does not support the severity of the administration's budget proposals. We do believe there is room for gradual reduction in payments under Part A.

While the administration's proposals for reductions in indirect medical education are too severe, threatening the viability of institutions which provide the highest levels of care to the sickest patients, a gradual reduction may be possible.

Similarly, continuation of the 15 percent reduction in capital payments may well be warranted, but increasing the rate to 25 percent could prevent needed rehabilitation of the deteriorating physical plants of our large city hospitals.

AARP supports ProPac's recommendations with respect to the annual update for the hospital market basket. We are concerned about hospitals which serve disproportionately high numbers of Medicare patients. Although perhaps some hospitals should close, we are concerned about closures which cut off access to care for less mobile persons.

Third, despite efforts to control Part B costs, Part B continues to be one of the fastest-growing domestic programs. This strains the Federal budget and the pocketbooks of beneficiaries.

The growth of the program is attributable to both increases in price and volume of services delivered. Beneficiaries have strong reasons to support further action to control spending in Part B.

Annual Part B premiums have increased 91 percent since 1984, and coinsurance has increased from just over $2 billion in 1981 to over $7 billion in 1988.

The administration's budget would reduce payments to physicians by $2 billion and raise an additional $600 million by continuing the requirement that Part B premiums equal 25 percent of program costs. A cut of this magnitude would be excessive.

The Association does not support the continuation of the requirement that Part B premiums equal 25 percent of program costs. While beneficiaries want to pay their fair share of Medicare costs, they cannot be expected to continue to pay 25 percent of the costs of a program over which they have no control.

Some claim increases in volume of costs by beneficiary demands for doctor services. Mr. Chairman, I would like to state very clearly that the doctor, not the patient, is the decisionmaker concerning tests and procedures.

The administration's budget calls for reducing certain overpriced procedures. AARP has supported similar reductions in the past and would be prepared again to support an approach which would

reduce overpriced procedures while investing some of the savings in undervalued services, such as primary care.

We would point out, however, when such investment occurs, beneficiary coinsurance amount actually goes up for these services, increasing costs to the patient. We know from past history that when price increases are limited or prices reduced, patients must be protected from cost shifting.

Congress has acted to do so in the past through limits on balanced billing. We strongly urge continuation of this action.

Ultimately, however, we need long-term cost containment of Part B. We urge you to make decisions concerning Part B which will be consistent with efforts to reform Part B over time. We look forward to working with you on this challenge.

Thank you.

[The prepared statement of Ms. Dixon follows:]

STATEMENT

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

HOUSE AGING COMMITTEE

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

ON

MEDICARE AND THE FEDERAL BUDGET

MARCH 23, 1989

PRESENTED BY:

Margaret A. Dixon
American Association
of Retired Persons

The American Association of Retired Persons (AARP) representing Americans age 50 and above appreciates this opportunity to share its views on the FY 1990 Medicare budget. The budget and deficit reduction continue to be issues which AARP members see as major concerns. In fact, in our last member survey, 66 percent rated deficit reduction as "one of the most important issues or problems" facing the country. This concern is not surprising since older Americans express fear that continuing large deficits will weaken the economy overall and also are deeply concerned about passing on a legacy of debt to their children.

At the same time, older Americans are concerned that federal programs which meet the needs of individuals, old and young, are not being adequately funded. Of particular concern are those programs which serve those who are economically vulnerable. In addition, AARP members (like Americans of all ages) express a strong desire to protect Social Security and Medicare.

AARP has long supported responsible deficit reduction and hopes to work with the Administration and this Committee in continuing this tradition. The Association believes that we all must continue to promote responsible, fair and effective deficit reduction -- deficit reduction which share the burdens, takes into account previous sacrifices, and recognizes that progress will be minimal if we only focus on the spending side of the ledger.

Some have argued that what we need is a dramatic bold stroke. Putting aside whether that would be good for the economy, it is far more important to have a predictable and steady deficit reduction strategy which reduces the deficit gradually. Such an approach should remove, over time, the Social Security Trust Funds from the deficit calculation.

Prior to examining in detail the subject of this hearing -- the FY 1990 Medicare budget -- we would like to express some general concerns about the budget proposals submitted by President Bush. First, the overall structure of the budget puts many domestic discretionary programs which assist lower income Americans at risk, since most of these programs are in the "black box" (the group of programs to be frozen at last year's levels or cut to make room for program expansion). These programs, such as the Low-Income Home Energy Assistance Program (LIHEAP) have already been significantly reduced. (Since 1985, LIHEAP has been cut more than 40 percent.) Using the criteria of both fairness and recognizing past sacrifices, these domestic programs should not be slated for cuts.

Second, even programs in the "black box" which are not identified for further cuts will face real reductions under the Bush proposal. The budget calls for a nominal freeze in these programs, leaving them at the same dollar levels as in FY 1989. In contrast, the Bush request for defense is a "freeze" at a level that includes an inflation adjustment. A nominal freeze on

domestic programs means that they will not be able to provide the same level of service in FY 1990 as they provided in FY 1989.

Third, the "black box" includes administrative expenses for the Social Security Administration (SSA). SSA has already absorbed a staff cut of almost 17,000 in the past four years. There is increasing concern that SSA cannot adequately serve the public at current staffing levels and that further cuts would simply amplify existing problems. Further, reducing the administrative expenses associated with the Social Security Trust Fund reserves and does not free up money for other programs.

Finally, the budget continues the request to freeze federal civilian and military retirees' Cost-of-Living Adjustment for one year and then reduce the COLA by one percent a year for the following two years. This is a fundamental breach of faith with these retirees. Further, these types of proposals fail to recognize that a COLA is not a benefit increase, but rather the only way that retirees can maintain their purchasing power.

Before addressing the Administration's proposals for Medicare we would like to comment on the Administration's Medicaid proposals.

MEDICAID

President Bush's budget calls for improvements in Medicaid to reach more poor pregnant women and young children. Under current law, states are required to phase in Medicaid coverage for all pregnant women and infants below the poverty line. The Bush budget proposes to extend mandatory coverage for pregnant women and infants up to 130 percent of poverty.

At the same time, however, the Bush Budget fails to include any new funds to cover these expansions. Every dollar in increased Medicaid funding to cover these expansions is offset by a dollar in Medicaid cuts. As a result, the total amount requested is the same as the amount the Office of Management and Budget (OMB) has said is needed to fund Medicaid under current law without any expansions.

This would have the effect of reducing Medicaid payments to states by $340 million and in turn use all of these Federal savings to finance improvements in coverage for pregnant women and children. This proposal would force states to bear the entire cost of the required improvements. In the absence of additional funding, our fear is that states would be forced to cut back on other aspects of their Medicaid programs to bear the costs of needed improvements.

MEDICARE

The Bush Budget proposes $5.2 billion in Medicare cuts in 1990. Sixty percent of the reductions would be made in Part A with the remaining 40 percent from Part B.

Since 1980, concerns about the economy and the deficit have driven Federal-policy makers each year to take steps to curb the rate of increase in spending under Medicare. Initially, most of this effort focused on the hospital portion of the program resulting in the creation of the Prospective Payment System (PPS). Part A continues to increase at about 10 percent annually. However, Part B which has also been the subject of cost containment efforts continues to increase at an annual average rate of 17 percent.

The foremost consideration must be access to affordable quality health care. Any cuts in Medicare must be undertaken with this in mind. Given the fiscal constraints of the budget and continued growth of Medicare, it would be unrealistic to think that Medicare would not be subject to some cuts. Therefore, the question we must confront is the extent and nature of the cuts.

Projections concerning the solvency of the HI Trust Fund show improvement, but Part A will require continued close oversight to assure that Part A remains solvent. But to affect long term reduction, Medicare's Part B is where much of the work must be

focused. However, changes in Part B should not be just for purely cost containment. We must begin to seriously address payment reform and create a more rational, equitable and fair payment system that also slows the rate of increase in costs.

The following sections outline areas which warrant attention. Reductions in Medicare must be viewed in the context of a larger package which assumes constraints in defense spending as well as other domestic spending and additional revenues.

PART A OF MEDICARE

Part A has borne most of the recent Medicare budget cuts. The Association does not believe that Medicare should assure providers a sure return on investment, rather it is our policy that Medicare rates should be sufficient on average to compensate providers fairly for service to Medicare beneficiaries.

Indirect Medical Education

Reductions in Part A should be evaluated carefully for their potential impact on access and quality. However, it is difficult to assess the direct beneficiary impact of some proposals. In those cases, AARP urges Congress to act cautiously and not to make radical reductions.

For example, President Bush's budget recommends severe and

immediate reductions for indirect medical education payments. This proposal could threaten the viability of institutions which provide the highest levels of care to the sickest patients. However, a gradual reduction in the indirect medical education payment as recently proposed by the Prospective Payment Assessment Commission (PROPAC) should be considered.

Hospital Capital Payments

Similarly, continuation of the 15 percent reduction in capital payments may be warranted, but increasing the rate of reduction to 25 percent as proposed in the Administration's budget, could prevent needed rehabilitation of the deteriorating physical plants of our large city hospitals. The capital payment system should be reformed to remove incentives toward unneeded capital expansion. But an overall deep cut in capital reimbursement would prevent needed rehabilitation in addition to unneeded expansion.

Update Factor

This year PROPAC again has undertaken a careful analysis of the factors affecting the hospital's cost of providing care, in order to recommend to Congress an appropriate adjustment to the Diagnosis Related Group (DRG) rates. PROPAC's analysis factors in the increase in the hospital market basket (the price of goods and services the hospital must purchase to operate), the differences in operating costs between urban and rural hospitals, costs of new technology, and reduces the total by increases in hospital productivity, changes in case-mix and a reduction for

prior overpayments.

Rural and inner city hospitals are of particular concern to AARP. These hospitals which serve disporportionately high numbers of Medicare patients, have suffered the most severe losses and some have closed. Although some hospitals should close, we are concerned about closures which cut off access to care for less mobile persons. Therefore, AARP supports PROPAC's recommendations concerning the hospital update factor.

Based on its analysis, PROPAC is recommending an average hospital update factor of 4.9 percent which is slightly less than the increases in the hospital market basket. PROPAC further breaks down its recommendation into separate amounts reflecting the different costs in rural, large urban and other urban hospitals. The recommended update is 5.6 percent for rural hospitals, 5 percent for large urban and 4.5 percent for other urban hospitals. AARP urges Congress to consider this proposal seriously.

PART B OF MEDICARE

The Effect of Part B Growth

Part B, despite efforts to control costs, continues to be one of the fastest growing domestic programs, growing at an average rate of 17 percent. General revenue financing of the

Supplementary Medical Insurance (SMI) Trust Fund protects it from insolvency, but the rapid infusion of general revenues and escalating premiums into the SMI Trust Fund strains the Federal budget and beneficiaries alike. The growth of the program is attributable both to price increases and increases in volume and intensity of services per beneficiary.

Beneficiaries have strong reasons to support further actions to control spending in Part B. Despite cost containment efforts, beneficiary out-of-pocket costs continue to rise rapidly. Annual Part B premiums have increased 91 percent since 1984 -- from $175.20 to $334.80 exclusive of the monthly catastrophic coverage premium all Part B enrollees will pay. Coinsurance amounts continue to escalate. Aged beneficiaries paid over $7 billion in coinsurance alone in 1988. From 1981 to 1987, coinsurance increased from $2.1 billion to over $6 billion.

Past Cost Containment Efforts

Since 1984, Congress has been driven by the need for budget savings from Part B. Congress froze physicians' fees for almost two years. Yet expenditures continued at double digit rates. In 1987, Congress gave the Secretary of Health and Human services authority to reduce Medicare payments for certain services which are determined not to be "inherently" reasonable. Congress also ordered reductions in reimbursement for a specified list of "over-priced" procedures, most of which relied on technology and were surgical procedures.

The Bush Budget Proposals

The Bush budget proposes reducing payments to providers by $2 billion and raising $600 million by continuing the requirement that beneficiary premiums equal 25 percent of Part B costs.

As we have outlined above, increases in the Part B premium and the amount paid through coinsurance are straining the pocketbooks of Medicare beneficiaries. Of particular concern to AARP is the Administration's proposal to extend the requirement that premiums equal 25 percent of Part B expenditures. This requirement is due to expire at the end of this calender year.

The Association does not support the extension of the 25 percent requirement. While beneficiaries want to pay their fair share of Medicare costs, they cannot be expected to continue to pay 25 percent of a liability over which they have no control. Although the hold harmless requirement does not permit a beneficiary's Social Security check to decrease, a growing number of beneficiaries are seeing their cost-of-living adjustments wiped out by the increases in their Part B premium.

The Administration achieves further savings in Part B through a freeze on the Medicare Economic Index (MEI) and reduced payments for radiology, surgery, and anesthesiology; "over-priced" procedures; and limiting reimbursement for new physicians.

Past history has shown us that when physician's fees are frozen or reduced, savings have been diminished because of an increase in the volume of services performed. Some suggest that the increase in volume is beneficiary induced. The Association believes, that the doctor, not the patient, is still the decision maker when it comes to ordering tests and performing procedures. Thus, the direct beneficiary impact of price reductions and freezes is increased out-of-pocket costs through premiums, coinsurance amounts and balance billing.

Because we do not yet have concepts developed to address the volume issue, Congress has little choice but to take steps toward reducing prices of some services and controlling overall increases in prices. AARP supports the concept of reductions in "over-priced" procedures with investment of some of the savings in currently "under-valued" services such as primary care. This would be in keeping with past actions of Congress. We would like to point out that when savings are reinvested in "under-valued" services such as primary care, beneficiaries pay more for those services through their coinsurance.

When Congress has reduced prices of specific services, limits on balance billing have been put into place to prevent cost-shifting to the beneficiary. We urge Congress to continue to follow this concept. In addition, the limits placed by the Maximum Allowable Actual Charge have held balance billing relatively stable over the past couple of years. We believe that beneficiaries should

share fully in the savings we achieve in the budget, and not bear the burden through cost-shifting.

We must achieve realistic savings from Part B -- but we must begin to address the broader issue of Part B reform in order to assure that Medicare provides access to doctors' services and costs are controlled. The goals of budget deficit reduction efforts must work consistently with the goals of reform.

In enacting budget reductions in Part B, AARP asks Congress to also examine the issue of Physician Payment Reform. As you know the Physician Payment Review Commission will be reporting to Congress in April with recommendations for reform. Beneficiaries and doctors need reform of the system to assure access by bringing rationality to the payment system and to achieve cost containment.

Reform will often be discussed in terms of the impact in the aggregate. Patients do not visit a physician in the "aggregate". Patients encounter specific medical problems and need to see specific physicians.

Conclusions

Recent budgetary constraints on doctors' services have been accompanied by enhanced beneficiary protections in the form of increased assignment, balance billing limits. These policies provide a structure from which reform of Part B can take place.

However, strategies to reduce the deficit by controlling only the price of services will not ultimately continue to assure access to appropriate care and will not be successful because of the unabated growth of volume. Thus the costs of the program for beneficiaries whose premiums and taxes help finance Medicare will continue to increase rapidly as well.

To achieve more effective controls over spending new policies will be needed to address the volume issues. Volume is a more troublesome and sensitive area to address. The search for budgetary savings during 1989 will probably take priority over a more deliberate approach toward physician payment reform issues. The longer-range reforms will require more careful research and further analysis before all their implications for beneficiaries and patient are understood.

The challenge is to find a balance that fosters access to affordable quality health care while prudently controlling increases in health care costs. The Association looks forward to working with Congress towards this goal.

Chairman ROYBAL. Thank you, Ms. Dixon.
The Chair now recognizes Ms. Johnson.

STATEMENT OF KAY JOHNSON, ACTING DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. JOHNSON. Thank you, Mr. Chairman.

My name is Kay Johnson, and I am the Director of the Health Division of the Children's Defense Fund, and on behalf of the Children's Defense Fund, I would like to thank you for this opportunity to testify today regarding Medicaid budget priorities for the 1990s and their impact on the health of children.

The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of low income and minority children. For more than 15 years, our efforts to improve programs and policies for poor children have included extensive work on Medicaid reforms.

I want to commend you, Mr. Chairman, for your interest in children and for holding this hearing today to focus attention on budget priorities in the 1990s for our largest public health financing programs, Medicare and Medicaid.

For millions of low income families, Medicaid has been the key to adequate access to needed health care. However, erosions in family income and health insurance have led to widening cracks in the health care system which the current Medicaid program has been unable to fill.

In order to appreciate the size of this problem and the barriers to health care services which exist for children, we must consider three questions. One; what is the extent of health insurance coverage for low income families today? Two; what is the relationship between insurance status, health care utilization, and the health status of children and pregnant women? And three; what resources are needed to improve the adequacy of public health financing programs, particularly Medicaid, for low income families?

In the interest of time, I will summarize my testimony today. However, I would like to submit a complete written statement for the record.

[The prepared statement of Ms. Johnson follows:]

Children's Defense Fund

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Testimony of
Kay Johnson
Acting Director, Health Division
Children's Defense Fund

Hearing Before the
House Select Committee on Aging
on
Medicaid Budget Priorities and
Their Effect on Maternal and Child Health

March 23, 1989

Mr. Chairman and Members of the Committee:

On behalf of the Children's Defense Fund (CDF) I want to thank you for this opportunity to testify today regarding Medicaid budget priorities in the 1990s and their impact on the health of children. The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of low income and minority children. For more than 15 years, our efforts to improve programs and policies for poor children have included extensive work on Medicaid reforms.

I want to commend you, Mr. Chairman, for holding this hearing today to focus attention on budget priorities in the 1990s for our key public health financing programs, Medicare and Medicaid. For millions of low income families, Medicaid has been the key to adequate access to needed health care. However, erosions in family income, health insurance, and health status have led to widening cracks in our health care system which the current Medicaid program has been unable to fill.

In order to appreciate the size of this problem and the barriers to health care services which exist for children and families, we must consider the following questions:

- What is the extent of health insurance coverage for low income families, particularly children and pregnant women?
- What is the relationship between insurance status, health care utilization, and the health status of children and pregnant women?

- What resources are needed to improve the adequacy of public health financing programs, particularly Medicaid, for low income familes?

In the interest of time, I will briefly summarize my testimony today. However, I would like to submit a complete written statement for the record.

1. WHAT IS THE EXTENT OF HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN?

In recent years, the problem of uninsuredness has been growing. Children are especially likely to be uninsured as a group -- representing approximately one-third of the 37 million uninsured Americans under age 65.[1] As a result of reductions in coverage under employer-based health insurance plans and reductions in federal and state public insurance programs for low-income children, fewer children today have health insurance coverage.

Poor children, whose families generally lack the means to pay for health care expenses "out-of-pocket" are among those most likely to be uninsured.

- Between 1980 and 1985, the proportion of children under age 18 covered by employer insurance fell by 6 percent (from 64.6 percent to 60.6 percent). Among poor children under age 18, the proportion privately covered declined by one-quarter, from 16.9 percent to 12.8 percent. [2]

- In 1986, nearly one out of every 5 children in families -- over 11 million nationwide--had no health insurance, public or private. [3] (Table 1)

- By 1986 nearly one-third of all poor children were completely uninsured. This translates into 4 million poor children nationwide. While an estimated 1.5 million children have been added to the Medicaid program since 1986, the remaining 2.5 million lack the key to access to health care--insurance.

Table 1

Insurance Status of Children Younger than 18 in Families, by Income[1], Race, and Insurance Status, U.S., 1986

Income as a percent of poverty	All Races			White			Black		
	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All
Children in Families (in thousands)	12,715	26,355	62,745	8,070	18,836	50,934	4,129	6,560	9,606
Percentage of insured children by type of coverage[2]									
Medicaid alone or with other coverage	52.3%	30.3%	13.4%	47.2%	25.2%	9.9%	61.6%	43.8%	31.4%
Medicaid only	48.3%	26.8%	11.7%	42.9%	21.7%	8.4%	59.0%	40.7%	28.7%
Employer coverage	11.5%	33.6%	61.4%	13.4%	37.3%	65.9%	7.9%	23.6%	39.0%
VA, CHAMPUS, military[3]	2.2%	3.8%	3.9%	2.7%	4.3%	3.8%	—	1.4%	4.1%
Other health insurance	6.0%	7.1%	7.6%	7.7%	8.2%	8.2%	—	2.9%	4.4%
Percentage of children insured	67.6%	69.6%	81.1%	66.3%	69.6%	82.5%	69.9%	69.1%	73.6%
Percentage of children uninsured	32.4%	30.4%	18.9%	33.7%	30.4%	17.5%	30.1%	30.9%	26.4%

[1]Income measured as a percentage of the federal poverty level.

[2]Percentages may not equal 100 percent because some children have insurance from more than one source.

[3]The U.S. Department of Defense covers health care for members of the military and their dependents, including children, at military institutions and at civilian facilities.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

- In 1986, more than 4 out of every 10 children in employed poor families had no health insurance public or private. (Table 2, Figure 1) These children have traditionally been left outside of the scope of the Medicaid program and, increasingly, their families lack employer-based dependent coverage.

In fact, the absence of health insurance, public or private, is most clearly seen in low income working families. Children in low income working families are less likely to have access to employer-based family coverage, and yet nonetheless are unlikely to be eligible for Medicaid. Many children in such families could be classified as "near-poor" (with family incomes between 100 and 200 percent of the federal poverty level).

- In 1986, nearly 3 out of 10 children in near-poor families had no health insurance. (Table 2A, Figure 2)

- In that year, just over half of near-poor children had private, employer-based health insurance coverage. Moreover, among this group, the full cost of the children's premiums was covered by the employer or union in only 32 percent of the cases.

The best way to ensure that a child will begin life as healthy as possible, is to ensure the health of the mother during pregnancy through prenatal care. Women of childbearing age need access to health care, especially during a pregnancy. Yet inadequate health insurance coverage acts as a barrier to health care for women.

- Among women of childbearing age (15-44 years), 9.5 million had no health insurance, public or private, in 1985. If women who have some health insurance but lack adequate maternity care coverage were included, then over 14 million women were completely unprotected against the cost of maternity care in 1985. [4]

While recent federal changes in Medicaid ensure coverage of all poor pregnant women beginning in 1990, millions of near-poor

FIGURE 1

UNINSURED CHILDREN IN EMPLOYED FAMILIES, BY AGE, 1986

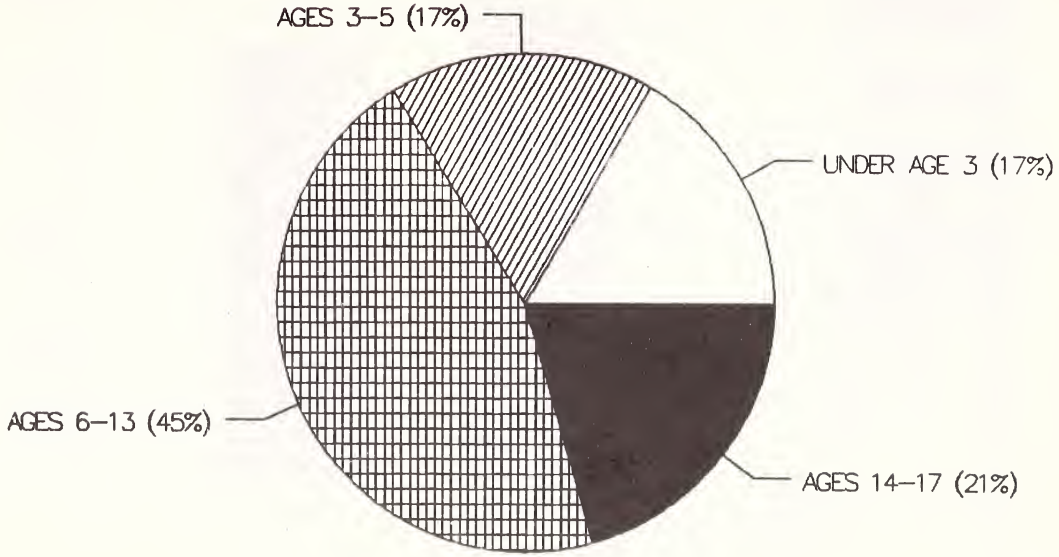


Table 2

Percentage of Children in Families with Employer-Based Coverage with All Premiums Paid by Employer or Union, by Income[1], Age, and Race, U.S., 1986

	Total Number of Children With Employer-Based Coverage (in thousands)				Percentage of Children with All coverage Costs Paid by Employer or Union			
Income Level	Less Than 100%	Less Than 200%	Less Than 400%	All	Less Than 100%	Less Than 200%	Less Than 400%	All
All races								
Under age 6	593	3,345	9,571	13,125	28.2%	31.0%	34.8%	37.9%
Ages 6-17	863	5,503	17,610	25,415	26.8%	31.8%	36.1%	38.4%
Total	1,456	8,848	27,181	38,540	27.3%	31.5%	35.7%	38.2%
White								
Under age 6	468	2,773	8,330	11,533	29.7%	31.9%	35.9%	38.8%
Ages 6-17	611	4,256	14,925	22,018	33.4%	35.0%	37.7%	39.7%
Total	1,079	7,029	23,255	33,551	31.8%	33.8%	37.0%	39.4%
Black								
Under age 6	106	479	990	1,177	—	25.5%	26.3%	27.8%
Ages 6-17	221	1,067	2,166	2,567	—	20.2%	26.0%	27.6%
Total	327	1,546	3,156	3,744	—	21.9%	26.1%	27.6%

[1]Income measured as a percentage of the federal poverty level.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

FIGURE 2

UNINSURED CHILDREN IN EMPLOYED FAMILIES BY INCOME, 1986

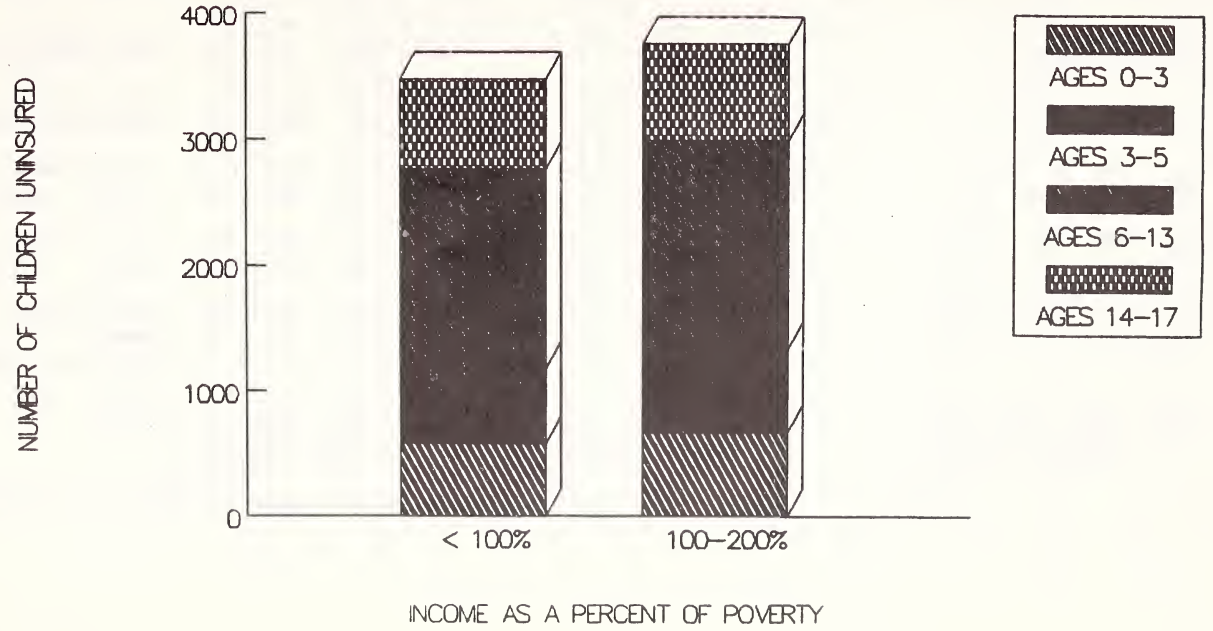


TABLE 2A. CHILDREN AGE 0-17 YEARSIN FAMILIES BY INCOME, RACE, AND INSURANCE STATUS, 1986

		ALL RACES (numbers in thousands)				WHITE (numbers in thousands)				BLACK (numbers in thousands)			
		(100%	100-200	(200%	ALL	(100%	100-200	(200%	ALL	(100%	100-200	(200%	ALL
ALL CHILDREN	(number)	12,715	13,640	26,355	62,745	8,070	10,766	18,836	50,934	4,129	2,431	6,560	9,606
INSURED CHILDREN BY TYPE OF COVERAGE													
WITH MEDICAID	(number)	6,647	1,351	7,998	8,438	3,808	945	4,753	5,045	2,545	330	2,875	3,013
	(percent of total)	52.3%	9.9%	30.3%	13.4%	47.2%	8.8%	25.2%	9.9%	61.6%	13.6%	43.8%	31.4%
WITH MEDICAID ONLY	(number)	6,145	928	7,073	7,332	3,462	632	4,094	4,260	2,437	230	2,667	2,754
	(percent of total)	48.3%	6.8%	26.8%	11.7%	42.9%	5.9%	21.7%	8.4%	59.0%	9.5%	40.7%	28.7%
WITH EMPLOYER COVERAGE	(number)	1,456	7,392	8,848	38,540	1,079	5,950	7,029	33,551	327	1,219	1,546	3,744
	(percent of total)	11.5%	54.2%	33.6%	61.4%	13.4%	55.3%	37.3%	65.9%	7.9%	50.1%	23.6%	39.0%
WITH VA. CHAMPUS, MILITARY	(number)	274	724	998	2,424	216	589	805	1,916	--	--	94	394
	(percent of total)	2.2%	5.3%	3.8%	3.9%	2.7%	5.5%	4.3%	3.8%	--	--	1.4%	4.1%
WITH OTHER HEALTH INSURANCE	(number	760	1,118	1,878	4,794	625	922	1,547	4,187	--	--	189	422
	(percent of total)	6.0%	8.2%	7.1%	7.6%	7.7%	8.6%	8.2%	8.2%	--	--	2.9%	4.4%
TOTAL CHILDREN INSURED	(number)	8,600	9,731	18,331	50,882	5,350	7,762	13,112	42,030	2,887	1,643	4,530	7,067
	(percent of total)	67.6%	71.3%	69.6%	81.1%	66.3%	72.1%	69.6%	82.5%	69.9%	67.6%	69.1%	73.6%
TOTAL CHILDREN UNCOVERED	(number)	4,115	3,909	8,024	11,863	2,720	3,004	5,724	8,904	1,242	788	2,030	2,539
	(percent of total)	32.4%	28.7%	30.4%	18.9%	33.7%	27.9%	30.4%	17.5%	30.1%	32.4%	30.9%	26.4%

women continue to be uninsured or underinsured. These women, generally young, married, and in a employed family with an annual income of just under $20,000, are most typical of those who give birth today. [5]

2. WHAT IS THE RELATIONSHIP BETWEEN INSURANCE STATUS, HEALTH CARE UTILIZATION, AND HEALTH STATUS?

Studies have shown that health insurance is a significant determinant of health care utilization. The uninsured use substantially fewer services than their insured counterparts, even when health status and the need for services is taken into account.[6] Research also has shown that even among the poorest families, health care coverage can bring health care utilization up to average levels. [7]

- National survey data reveal that low-income uninsured children have a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status, uninsured children remain most likely to have no physician visits in a year. [8]

- Even among children with identified disabilities who participate in special education programs, lack of health insurance has been found to be associated with reduced access to necessary health care. [9]

- However, poor children with Medicaid coverage are far more likely than uninsured poor children to have a regular source of health care and to visit a physician in a year. Medicaid recipient children use services in a pattern similar to that of their affluent, privately insured counterparts. [10]

- Uninsured low income women are less likely to receive care early in pregnancy and are twice as likely to receive late or no prenatal care. [11]

Adequate access to health care is critical to maternal and child health and saves money by preventing unnecessary illness, disability, and death.

Maternity care, beginning with prenatal care in the critical first three months of pregnancy and continuing through the birth of a child, can dramatically improve maternal and infant health. An infant born to a women receiving no prenatal care is more than 3 times more likely to die in the first year of life.[12] Prenatal care can save $3 for every $1 invested. [13] Yet each year, millions of infants are born to women who did not receive early care.

- In 1986, about one in four babies nationwide was born to a mother who did not benefit from early care. (Table 3)
- In that year, only 68 percent of all births occurred among mothers whose prenatal care could be considered adequate, even in terms of timing and frequency of visits.[14]
- That year marked the seventh in a row in which the trend in receipt of late (beginning after the sixth month) or no prenatal care worsened or showed no improvement. In 1986, 70,000 infants were born without benefit of any prenatal care. [15]

The Institute of Medicine of the National Academy of Sciences reports that "financial barriers--particularly inadequate or no insurance and limited personal funds--were the most important obstacles reported in 15 studies of women who received insufficient care." [16] From New York City to Oklahoma City, these studies document the financial barriers which keep women from receiving early and adequate prenatal care.

Immunizations, beginning in the first months of life, can eliminate the death and disability that can result from now-preventable, childhood diseases such as measles, mumps, pertussis

TABLE 3

TABLE 1.1

United States Fact Sheet, 1986

	White	Nonwhite Black	Nonwhite Total	Total
Births				
To All Women	2,970,439	621,221	786,108	3,756,547
To women age 19 and under	315,335	141,606	156,746	472,081
To women under age 15	4,007	5,877	6,169	10,176
Teen Births				
As percentage of all births				
To women age 19 and under	10.6%	22.8%	19.9%	12.6%
To women under age 15	0.1%	0.9%	0.8%	0.3%
Low-Birthweight Births				
Percentage of births that were low birthweight:				
To all women	5.6%	12.5%	11.2%	6.8%
To women age 19 and under	7.7%	13.3%	12.7%	9.4%
Percentage of all low-birthweight births:				
To women age 19 and under	14.4%	24.1%	22.6%	17.3%
Prenatal Care				
Percentage of Babies Born to Women Who:				
Began prenatal care in the first trimester				
All women	79.2%	61.6%	63.7%	75.9%
Women age 19 and under	55.9%	46.8%	47.1%	53.0%
Began prenatal care in the third trimester or not at all				
All women	5.0%	10.6%	9.9%	6.0%
Women age 19 and under	11.6%	15.0%	15.0%	12.7%
Received adequate prenatal care				
All women	72.6%	50.6%	51.8%	68.4%
Received inadequate prenatal care				
All women	6.3%	15.3%	14.7%	8.0%
Infant Mortality				
Infant Deaths per 1,000 Live Births				
Total infant deaths	8.9	18.0	15.7	10.4
Neonatal deaths	5.8	11.7	10.1	6.7
Postneonatal deaths	3.1	6.3	5.6	3.6

SOURCE: National Center for Health Statistics. Calculations by Children's Defense Fund.

(whooping cough), diphtheria, tetanus, polio, and meningitis. Childhood immunizations save $10 for every $1 invested.[17] Inadequate immunization levels lead to outbreaks of preventable disease. However, between 1980 and 1985, immunization levels for our nation's infants and toddlers eroded substanially.[18] (Table 4, Figure 3)

- In 1985, the proportion of infants younger than one with at least one dose of polio or diphtheria, tetanus, and pertussis (DTP) vaccine was lower than in 1980. Among all nonwhite infants, the proportion receiving at least one dose of polio vaccine fell by more than 20 percent, while the proportion receiving at least one dose of DTP vaccine fell nearly as sharply.

- Because the 1985 DTP immunization status of children who had reached age one showed some improvement, it appears that some families may have delayed immunizations and "caught up" later. This places many infants at unnecessary risk for preventable disease.

- Two-year-olds experienced erosion in immunization status in each vaccine category. The overall pattern indicates a significant decrease in the immunization status of two-year-olds.

Comprehensive primary and preventive care for children can detect and treat a wide range of health conditions before they become serious. Screening for lead poisoning, learning disabilities, vision impairments, and dental health needs can reduce the consequences of these health problems. Children who receive comprehensive primary health care have annual health costs 7 to 10 percent lower than those who do not. However, many children do not receive such preventive care.

- In 1986, as a result of inadequate access to health care, poor children were considerably more likely than affluent children to have had a routine physical in the previous year.[19]

Table 4 Percentage of Infants and Toddlers Who Were Fully Immunized[1], by Age and Race, U.S.[2], 1980 and 1985

Infants

		Polio	DTP[3]	Measles	Mumps	Rubella
Total	1980	80.0	84.2			
	1985	79.6	82.7	These vaccines are not recommended for children of this age.		
White	1980	80.9	84.9			
	1985	81.5	84.4			
Nonwhite	1980	73.2	79.0			
	1985	58.5	64.8			

Age one

		Polio	DTP	Measles	Mumps	Rubella
Total	1980	95.5	76.2			
	1985	95.2	78.3	These vaccines are not recommended for children of this age.		
White	1980	96.2	78.6			
	1985	96.9	80.1			
Nonwhite	1980	89.1	56.5			
	1985	82.3	64.9			

Age two

		Polio	DTP	Measles	Rubella	Mumps
Total	1980	80.7	87.0	83.0	83.2	80.2
	1985	76.7	85.8	81.7	77.3	78.9
White	1980	83.0	89.4	84.8	84.4	81.5
	1985	79.5	88.0	82.7	78.6	80.8
Nonwhite	1980	62.8	68.0	69.0	73.4	70.7
	1985	56.5	69.1	74.7	66.9	64.2

[1] Dosage levels are approximations of level needed to fully immunize a child of a given age: younger than age one, one or more doses of polio and DTP; at age one, one or more doses of polio and three or more doses of DTP; and at age two, three or more doses of polio and DTP and one dose of measles, rubella, and mumps vaccines.

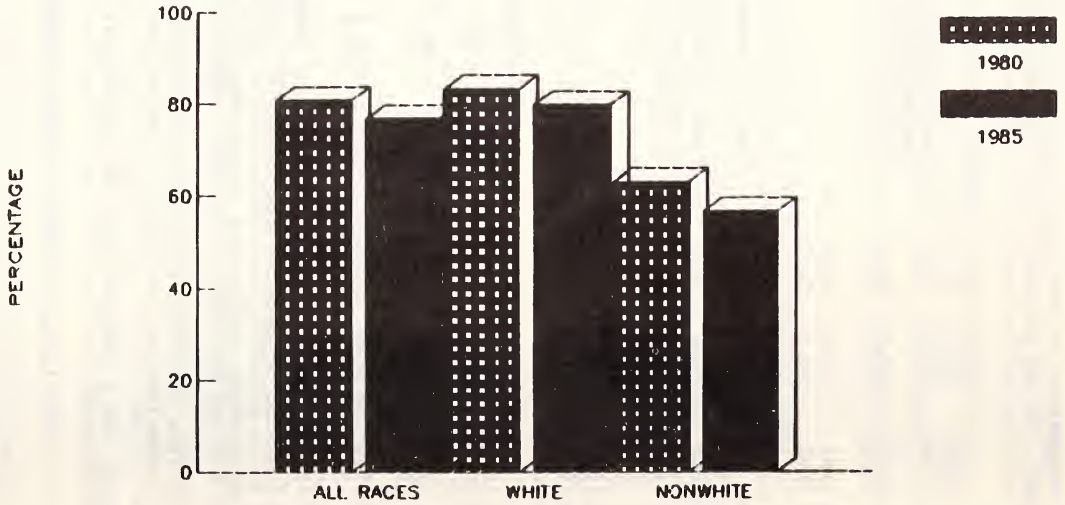
[2] Data are from the U.S. Immunization Survey sample confirmed by parent consultation with an immunization record.

[3] DTP stands for a combined dose of diphtheria, tetanus, and pertussis vaccines.

SOURCE: U.S. Immunization Survey, Centers for Disease Control.

FIGURE 3

POLIO IMMUNIZATION AMONG TWO-YEAR-OLDS, BY RACE, U.S., 1980 AND 1985



SOURCE: CHILDREN'S DEFENSE FUND

- National surveys indicate that poor children are at least 3 times more likely than affluent children to have never had a physician visit (5.4 percent and 1.6 percent, respectively).[20]

We understand how to keep most children healthy. We know that every child needs health care. Good medical care begins before a child's birth with comprehensive prenatal care. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child--whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses--should go without health care because a family cannot afford it. No pregnant woman should be denied prenatal care because she does not have enough money to pay for it.

The current gaps in insurance coverage and medical care among children are costly in both human and fiscal terms. Maternity and pediatric services have been found not only to be effective but also to be a remarkably cost-effective type of health care investment. Our highly sophisticated medical system can offer preventive or remedial care for most child health problems. Yet a series of events have left our children vulnerable to preventable childhood disease, disability, and death.

3. WHAT RESOURCES ARE NEEDED TO IMPROVE THE ADEQUACY OF MEDICAID COVERAGE FOR LOW INCOME FAMILIES, ESPECIALLY CHILDREN

In recent years, Congress has taken steps to improve access to health care for pregnant women, infants, and children. These preventive investments include changes in key maternal and child

health programs such as Medicaid, the Maternal and Child Health Block Grant, Community and Migrant Health Centers, childhood immunization, and health manpower programs.

Medicaid

The Medicaid program is the primary health care financing program for low income children and pregnant women.

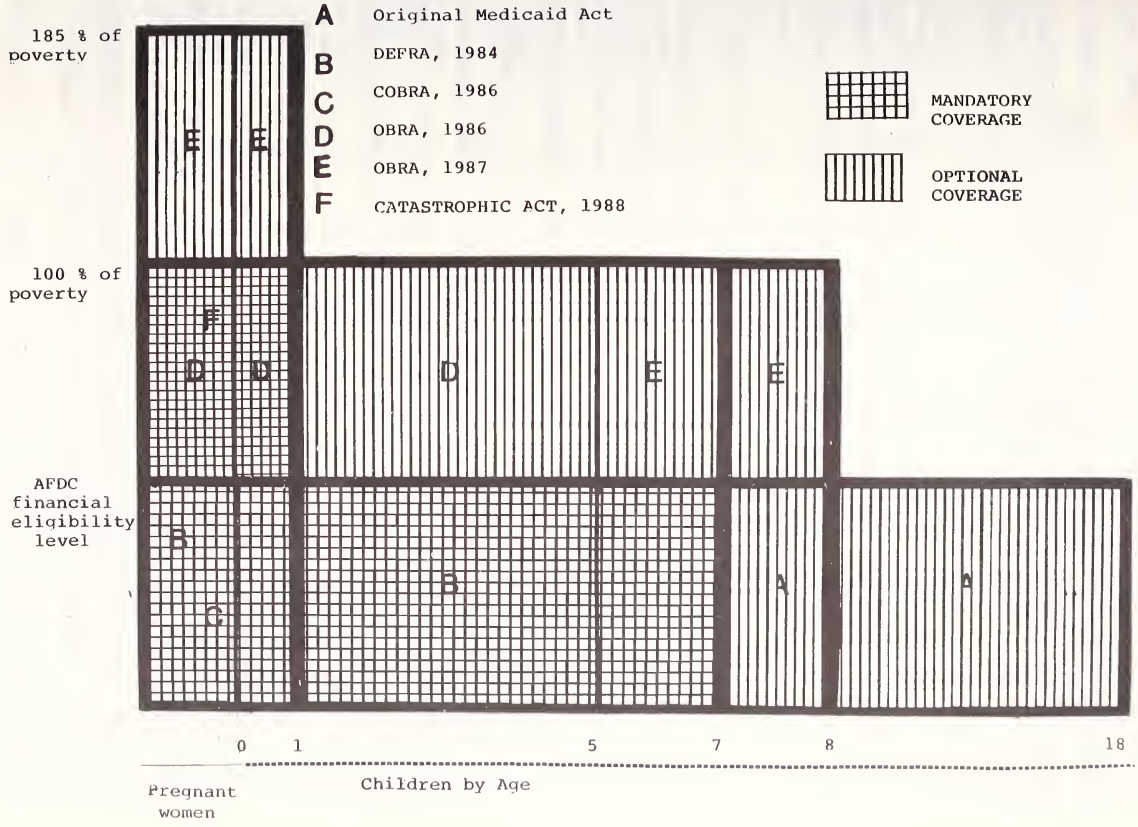
- In 1987, more that 11.6 million children under age 18 received services paid for by Medicaid. Children comprised 50 percent of all recipients.
- Despite its importance, Medicaid reached only about half of all poor children in 1987. Furthermore, children account for only approximately 1/3 percent of the total expenditures.
- Medicaid paid for maternity care for approximately one-half million births that year -- nearly one in every six U. S. births.

Because of the size and scope of the program, recent reforms in Medicaid have the potential to dramatically affect access to care for low income pregnant women, infants, and the youngest children. However, if we are to ensure health care access even for all poor children and pregnant women, Congress and the states must take additional steps to improve Medicaid in a number of ways.

A. **Recent Medicaid Changes To Benefit Pregnant Women and Children**

Since 1984, in an effort to improve maternal and child health among low income families, Congress has enacted a series of Medicaid improvements. (Figure 4) As a result, by 1990 all pregnant women and infants with family incomes below 100 percent of the federal poverty level ($9690 per year for a family of

FIGURE 4 MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN



three in 1988) will be covered by Medicaid in all states, and several states will have extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (roughly $18,000 per year for a family of three). (Table 5)

In addition, 30 states have used the option to extend coverage to some of the youngest children with family incomes below the poverty level. (Table 4) However, millions of poor children nationwide remain uncovered.

If all states extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (nine already do so), then Medicaid would be available to cover health care costs for nearly one out of two births in the United States. If coverage were extended to all children with family incomes below the federal poverty level, Medicaid would become a source of health care financing for one in five American children.[21] A substantial proportion of these families currently have no source of health care coverage, public or private.

B. **Issues Awaiting Further Action?**

Despite recent improvements, the Medicaid program continues to fall far short of fulfilling its mission to address the health care needs of poor Americans. Over 50 percent of the poor, and about 50 percent of poor children did not qualify for Medicaid last year. Strict eligibility rules, limitations on benefit packages which vary widely from state to state, and low provider

TABLE 5A Characteristics of State Medicaid Programs for Children and Pregnant Women 2/20/89

State	Expanded Financial Eligibility: Up to AFDC Need Level — All Children Under 18	Expanded Financial Eligibility: Up to 100% of Federal Poverty Level — Pregnant Women and Infants	Expanded Financial Eligibility: Up to 100% of Federal Poverty Level — Children Over Age One	Expanded Financial Eligibility: Above 100% of Fed. Poverty Level — Pregnant Women and Infants	Other Eligibility and Benefit Options: Age Cut-off for Children Up to 100% Poverty[1]	Other Eligibility and Benefit Options: Waived Asset Test	Other Eligibility and Benefit Options: Continuous Eligibility for Pregnant Women	Other Eligibility and Benefit Options: Presumptive Eligibility
Alabama	No	Yes	No	No	—	Yes	Yes	Yes
Alaska	Yes	Yes	No	No	—	No	No	No
Arizona	Yes	Yes	Yes	No	(5	Yes	Yes	No
Arkansas	Yes	Yes	Yes	No	(6(8)	No	Yes	Yes
California	Yes	Yes	No	Yes	—	No	No	No
Colorado	No	No	No	No	—	No	No	No
Connecticut	Yes	Yes	No	Yes	—	Yes	Yes	No
Delaware	Yes	Yes	Yes	No	(2	Yes	Yes	No
District of Columbia	Yes	Yes	Yes	No	(3	Yes	Yes	No
Florida	Yes	Yes	Yes	No	(6(8)	Yes	Yes	Yes
Georgia	Yes	Yes	Yes	No	(3(5)	Yes	No	Yes
Hawaii	No	Yes[2]	Yes	No	(1(5)	Yes	Yes	Yes
Idaho	No	Yes[2]	No	No	—	Yes	No	No
Illinois	Yes	Yes[2]	No	No	—	Yes	Yes	Yes
Indiana	No	Yes[2]	No	No	—	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	Yes	(3(5)	No	No	No
Kansas	Yes	Yes	Yes	No	(2	Yes	No	No
Kentucky	No	Yes	Yes	Yes	(2	No	Yes	No
Louisiana	No	Yes	Yes	No	(6(8)	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes	(5	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	No	(2	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	(5	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	Yes	(3(5)	Yes	Yes	No
Minnesota	Yes	Yes	No	Yes	—	Yes	Yes	No
Mississippi	Yes	Yes	Yes	Yes	(3(5)	No	Yes	No
Missouri	Yes	Yes	Yes	No	(3(5)	No	Yes	No
Montana	Yes	No	No	No	—	No	No	No
Nebraska	Yes	Yes	Yes	No	(3(5)	Yes	Yes	Yes
Nevada	No	No	No	No	—	No	No	No
New Hampshire	No	No	No	No	—	No	No	No
New Jersey	Yes	Yes	Yes	No	(2	Yes	Yes	Yes
New Mexico	No	Yes	Yes	No	(3(5)	No	Yes	Yes
New York	Yes	No	No	No	—	No	No	No
North Carolina	Yes	Yes	Yes	No	(3(5)	Yes	Yes	Yes
North Dakota	No	No	No	No	—	No	No	No
Ohio	Yes	Yes	No	No	—	Yes	Yes	No
Oklahoma	Yes	Yes	Yes	No	(2	Yes	Yes	No
Oregon	Yes	Yes	Yes	No	(3	Yes	Yes	No
Pennsylvania	Yes	Yes	Yes	No	(3(5)	Yes	No	Yes
Rhode Island	Yes	Yes	Yes	Yes	(6(8)	Yes	Yes	No
South Carolina	Yes	Yes	No	No	—	Yes	Yes	No
South Dakota	No	Yes	No	No	—	Yes	Yes	No
Tennessee	Yes	Yes	Yes	No	(5	Yes	Yes	Yes
Texas	Yes	Yes	Yes	No	(2(5)	No	Yes	Yes
Utah	Yes	Yes	No	No	—	Yes	Yes	Yes
Vermont	Yes	Yes	Yes	Yes	(6(8)	No	Yes	No
Virginia	No	Yes[2]	No	No	—	Yes	Yes	No
Washington	No	Yes	Yes	No	(3	No	Yes	No
West Virginia	No	Yes[3]	Yes	Yes[3]	(6(8)	Yes	Yes	No
Wisconsin	Yes	Yes	No	Yes	—	No	No	Yes
Wyoming	No	Yes	No	No	—	Yes	Yes	No
	35	45	30	13		33	37	20

[1] Coverage ends at the birthday which marks age designated. Number in parantheses indicates authorized age limit in states phasing in coverage of children below poverty.

[2] These states have expanded coverage for pregnant women and infants but are not covering all poor pregnant women and infants.

[3] 100% state funded.

State Medicaid Eligibility Levels for Children and Pregnant Women, 1988

2/20/89

TABLE 5B

Maximum Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for a Family of Three

State	Pregnant Women and Infants	Young Children[1]	Older Children	Medically Needy Income Level	Maximum AFDC Payment Level[2]
Alabama	100.0	14.6	14.6	—	14.6
Alaska	100.0	77.2	77.2	—	77.2
Arizona	100.0	100.0(5)	36.3	—	36.3
Arkansas	100.0	100.0(8)	25.3	34.1	25.3
California	185.0	82.1	82.1	110.5	82.1
Colorado	52.1	52.1	52.1	—	44.1(52.1)
Connecticut	185.0	77.2	77.2	87.9	77.2
Delaware	100.0	100.0(2)	39.5	—	39.5
District of Columbia	100.0	100.0(3)	46.9	60.1	46.9
Florida	100.0	100.0(8)	34.1	45.4	34.1
Georgia	100.0	100.0(5)	33.4	45.4	33.4
Hawaii	100.0	100.0(5)	59.9	59.9	59.9
Idaho	68.0	37.6	37.6	—	37.6
Illinois	100.0	42.4	42.4	56.7	42.4
Indiana	50.0	35.7	35.7	—	35.7
Iowa	150.0	100.0(5)	48.8	65.0	48.8
Kansas	100.0	100.0(2)	52.9	59.4	52.9
Kentucky	125.0	100.0(2)	27.0	36.2	27.0
Louisiana	100.0	100.0(8)	23.5	32.0	23.5
Maine	185.0	100.0(5)	71.0	69.1	51.5(71.0)
Maryland	100.0	100.0(2)	46.7	54.7	46.7
Massachusetts	185.0	100.0(5)	66.7	90.8	66.7
Michigan	185.0	100.0(5)	74.8	68.0	57.7(74.8)
Minnesota	185.0	65.9	65.9	87.8	65.9
Mississippi	185.0	100.0(5)	45.6	—	14.9(45.6)
Missouri	100.0	100.0(5)	34.9	—	34.9
Montana	50.5	44.5	44.5	50.5	44.5
Nebraska	100.0	100.0(5)	45.1	60.9	45.1
Nevada	40.9	40.9	40.9	—	40.9
New Hampshire	69.0	61.4	61.4	69.0	61.4
New Jersey	100.0	100.0(2)	52.5	70.1	52.5
New Mexico	100.0	100.0(5)	32.7	—	32.7
New York	82.4	82.4	82.4	78.5	82.4
North Carolina	100.0	100.0(5)	32.9	44.3	32.9
North Dakota	53.9	45.9	45.9	53.9	45.9
Ohio	100.0	38.3	38.3	—	38.3
Oklahoma	100.0	100.0(2)	58.3	53.6	38.4(58.3)
Oregon	100.0	100.0(3)	51.0	69.2	51.0
Pennsylvania	100.0	100.0(5)	49.8	55.7	49.8
Rhode Island	185.0	100.0(8)	64.0	85.7	64.0
South Carolina	100.0	49.9	49.9	—	24.9(49.9)
South Dakota	100.0	45.3	45.3	—	45.3
Tennessee	100.0	100.0(5)	45.2	28.9	21.4(45.2)
Texas	100.0	100.0(5)	22.8	33.1	22.8
Utah	100.0	62.2	62.2	62.0	46.6(62.2)
Vermont	185.0	100.0(8)	77.9	104.1	77.9
Virginia	100.0	43.8	43.8	44.3	43.8
Washington	90.0	90.0(3)	60.9	74.2	60.9
West Virginia	150.0	100.0(8)	30.8	35.9	30.8
Wisconsin	120.0[3]	64.0	64.0	85.3	64.0
Wyoming	100.0	44.6	44.6	—	44.6

[1] States have the option of coveraging children older than one born after September 30, 1983, with incomes above the AFDC payment level and up to the federal poverty level until their eighth birthday. The number in parentheses indicates the eventual age limit chosen by states electing this option.

[2] Most states use the AFDC payment level as the Medicaid income eligibility threshhold. Levels in states that have chosen to use the higher AFDC standard of need level to determine Medicaid eligibility are shown in parantheses.

[3] 100 percent state-funded.

reimbursement levels together create significant barriers to access. Federal eligibility rules currently do not allow coverage of many poor individuals, including poor children older than age 7 with family incomes above states' guidelines for the Aid to Fmailies With Dependent Children (AFDC) program (on average these levels remain below 50 percent of the federal poverty level). Even eligible persons find the application process so difficult that in some states as much as 50 percent of applicants are denied not on the basis of excess income but because of failure to comply with complex procedures.[22] Providers find that Medicaid reimbursement levels in many states are well below their costs. [23] Providers and patients also find that states' benefit packages may be so restrictive that necessary care cannot be provided in sufficient amount, scope, or duration.

This month a coalition of 172 public and private sector organizations, identified as the Health Policy Agenda for the American People, released a report on Medicaid. This report, entitled "Including the Poor," [24] found that after two decades of programmatic effort, 11 million poor Americans are uninsured and yet cannot qualify for Medicaid. The report made a series of policy recommendations for restructuring the Medicaid program so that it can be governed by national standards and goals and function more as an integral part of our national health care system. The application of the substance of these recommendations would be of great benefit to low income families,

and, the proposals, with their cost estimates, should be carefully reviewed by Congress.

However, incremental steps should be taken this year to further improve Medicaid's ability to serve low income children and pregnant women, as well as other vulnerable groups. If the nation is to make real progress in reducing infant and childhood death and disability, then the reform efforts undertaken since the mid-1980's must be expanded and strengthened. The following expenditures represent a basic level of investment in the health of America's children.

- **Medicaid coverage should be provided to all pregnant women and infants with family incomes below 185 percent of the federal poverty level.** Bi-partisan legislation (H.R. 800) has been introduced by Representatives Henry Waxman (D-CA), Mickey Leland (D-TX), Henry Hyde (R-IL), and others to phase-in such coverage, ensure expedited eligibility processes, and improve provider participation. The Congressional Budget Office (CBO) preliminarily estimates that this bill would have a cost of $23 million for FY 1990. Federal outlays of approximately $120 million over the next three years would be needed to begin the phase-in.

- **The Medicaid program should be expanded to cover all poor children.** Legislation designed to phase-in mandatory coverage of poor children and permit states to extend such coverage immediately (H.R. 833) has been introduced by Representatives Henry Waxman (D-CA), George Miller (D-CA), and others. For FY 1990, the federal cost for this legislation would be an estimated $65 million. The federal share of this expansion would be approximately $200 million over the next three years.

- **Medicaid coverage for children with severe or chronic disabilities, illness, and conditions should be restructured.** Congressman Waxman has introduced legislation which would take an initial step toward this goal by requiring that states offer Medicaid services in the community to technology-dependent children who would otherwise need institutional care (H.R. 832). The FY 1990 cost of this effort has been estimated to be $100 million.

- **Federal funding should be provided to permit states to improve their Medicaid programs in a number of additional ways. For example, policies which allow states to guarantee annual enrollment periods for children, eliminate resource tests, and conduct aggressive outreach programs are important steps in ensuring that Medicaid-eligible children, infants, and pregnant women enroll in the program early and receive the preventive and primary health care they need. These are low cost initiatives which make federal and states eligibility expansions meaningful at the local community level.**

CONCLUSIONS

In 1989, the United States stands alone with South Africa among industrialized nations in its failure to provide essential basic health care to pregnant women and children. President Bush has made coverage for low income pregnant women and children a priority. The commitment of federal funds through the budget process this year and into the 1990s is essential to enactment of reforms proposed by Congress and the President.

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Chairman ROYBAL. Without objection, the statement of every witness will be included in the record in its entirety.

We hope that you will be able to summarize and then we will go on for some brief questions. We will submit questions to each one of you in writing and fill the record with the answers that you will be giving this Committee as soon as possible.

We have to do this because we have on the Floor perhaps one of the most important pieces of legislation we will have this year. I said one of the most important, not the most important. This is in regard to the minimum wage.

Just a little while ago, we had one vote that I just barely missed, but, nevertheless, I am not recorded on it. There is one vote on the Floor now, which is no doubt another amendment, and then there will be a vote on final passage within the next 45 minutes to an hour.

I would like to recess at this time and come back to hear Mr. Chapman. I have a question for each one of you and then we will go on to close the hearing. I am asking you again to answer the questions that each Member will have in writing.

We will recess for another 10-15 minutes.

Thank you.

[Recess.]

Chairman ROYBAL. We will resume the hearing now and hear from Mr. Chapman.

STATEMENT OF THOMAS W. CHAPMAN, PRESIDENT, GREATER SOUTHEAST COMMUNITY HOSPITAL, WASHINGTON, DC, REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION

Mr. CHAPMAN. Thank you, Mr. Chairman.

My name is Thomas W. Chapman, and I am the President of Greater Southeast Community Hospital, a hospital here in the District of Columbia. I am presenting my testimony on behalf of the American Hospital Association and its 5300 members.

I have submitted to the Committee a full text and summary of that statement, and in respect for your time, I would not like to go through that, but I do have some specific comments and concerns I would like to share about the Medicare and Medicaid cuts, which impact on hospitals at the operating level.

The first area I would like to discuss with you is the whole issue of physician payments and hospital payments. There has been some discussion and presentation on that, and it has been noted that the incentives are quite different. Hospitals are and have been under the prospective payment program paid to contain costs within a specific payment amount. Physicians have not been, and, basically, at the operating and institutional level, that puts us at great odds and great conflict.

In terms of managing the prospective payment and all Federal health dollars, what we are essentially talking about is changing the patterns of care and behavior within each institution across the country. That is a long term and very complex process. We are working at it.

The next area I would like to talk about a little bit is the whole nursing home-hospital relationship.

Regarding the recently-published Mental Health Criteria and Certifications from HCFA, it is known as Transmittal 94, for Nursing Home Patients, this transmittal requires that all nursing home patients being discharged from hospitals receive psychiatric consultations.

I would like to provide you with a snapshot of a picture of its impact on one day of hospital operations. On February 27th, 1989, we had a total of five patients in our hospital waiting for completion of their mental health evaluation. These patients had been stable in excess of 30 days.

When approval was finally obtained, only then were they able to begin the nursing home placement process. This is a difficult area because, first of all, psychiatrists are very unclear about their own reimbursement under these regulations. They are also concerned about the medical-legal implications of rendering these opinions and diagnoses, and, thirdly, often times, if the patient is diagnosed to have a mental condition, there really is no place to send them.

These are not candidates for an acute care psychiatric unit. They are nursing home patients who may have a mental condition and would require special and very complex care.

Most importantly, what that is causing are great delays in addition to the delays we have previously experienced with most nursing home patients in hospitals and hospitals are not being reimbursed for those days.

Nursing homes are only required to hold open a bed for 14 days when a patient enters the hospital. If that bed is still available within 14 days, it can be used for another patient and, therefore, the hospital often ends up keeping nursing home patients even if they are not clinically ill or long beyond the time that they should be in a hospital.

Our hospital services 43 nursing homes. We are monitoring the impact of this provision very closely on our operating revenues. We expect that it will have a negative impact in 1989 and will grow worse in 1990.

It has become difficult, if not impossible, a task to manage these patients cost effectively for two basic reasons. One, the severity of illness, which you know quite a bit about, and they are sicker and sicker as the years go on, and, two, the earlier problem of the bed availability, which I mentioned, of 14 days.

The nursing home placement is also complicated. Regarding the issue of nursing home placement, in 1988, the average wait for an intermediate nursing home bed from a hospital was 16.6 days. As you know, we are not reimbursed at all for those days. The average wait for a skilled nursing home bed was about 17.3 days. These are costs the hospital must absorb and somehow pass on to other patients.

We have also a problem with the younger set. Boarder babies. These are babies that are abandoned, essentially, in pediatric units. They are delivered often and abandoned. The pediatric boarder babies became an important financial issue for our institution in 1986.

At any one time, the average occupancy runs from four to six babies, with an average stay of 6 months. The long stays are attributable to the difficulties in foster home placement, particularly for

the AIDS or HIV positive children, and Medicaid does not reimburse us for these stays at all.

I would like to now just mention a little bit about cost impact on payment and revenue. For most hospitals, Medicare revenues represent approximately 40 percent of their business, yet the losses a hospital experiences every year are highest from their Medicare business.

Our hospital alone will experience a loss of about 60 percent of its revenue from Medicare reimbursement.

D.R.G. payments have gradually become inadequate in covering the full cost of hospital in-patient care. Capital costs reimbursement has systematically been reduced, and the same is proving true for the direct and indirect medical education.

During the initial years of PPS, Congress told hospitals it would increase Medicare payments each year to cover increased costs. It has given hospitals only enough money to cover about half their increased costs over the past 5 years.

Congress has essentially cut out money that should have been set aside by Medicare at about the tune of $53 billion since the beginning of the program, as a result of both policy and fiscal changes.

Now, a little bit about hospital patient care margins. The difference between hospital revenues and expenses fell to one-tenth of 1 percent in 1987. It is expected to be negative for 1988 and then worse for 1989.

Nearly half of all hospitals are expected to lose money caring for Medicare patients in 1990. At my own hospital, the aggregate loss of Medicare is currently in excess of $9 million.

I would like to talk now about the Medicare beneficiaries. Most elderly patients are experiencing difficulty in meeting their Medicare deductibles. A consequence they attribute to the Federal budget cuts.

Others are exhausting their Medicare benefits and seeking supplemental Medicaid coverage while States are cutting back on that program.

Hospitals are seeing more and more of these patients as Medicaid has become the safety net for them. Reimbursement systems which limit payments to hospitals can result in less care being provided, particularly as reimbursement moves further from the actual cost of providing care. The principle holds true in any system that you have, whether it is a capital driven system or a social driven system.

The appropriate reimbursement must be there. That is why there are access barriers now in the United Kingdom and other countries that have had a completely different approach than us.

The inability of payments to cover costs postpones capital improvements, new construction, renovation and additions of new technology. This ultimately makes a hospital less attractive to full cost payers and eventually drives private patients away and the total costs up.

It is a deadly cycle which is counterproductive and creates a major difference in the quality of hospital facilities Medicare and Medicaid patients will be seen in. As new technology is available, fewer hospitals with large Medicaid and Medicare loads will be

able to acquire it and thus create inequality in medical, legal and possibly cost problems.

Research and development expenses for new technology and pharmaceuticals are rising. Federal payments will be affected by this. The only option is to restrict Medicaid and Medicare patients from accessing this technology and these new drug therapies. That has already been done with TPA and other procedures.

Hospitals really should not be in the position to make these kinds of decisions. Current payment systems encourage the purchase of only cost saving technology and avoids technology that adds immediate costs to the patient care, even if the new technology is life saving or quality enhancing, and in the long run, will lower costs.

Uncertainty regarding the future patient care and capital Federal payment systems combined with rapid increases in the cost of more sophisticated services will affect the quality of hospital care.

Declining occupancies, operating margins, and hospital closures are in every region in the country, and in the future, somehow we will have to rebuild the system at a very high price.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Chapman follows:]

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Statement
of the
American Hospital Association
before the
Select Committee on Aging
of the
United States House of Representatives
on
Medicare and Medicaid Budget Priorities for the 1990s

March 23, 1989

Summary

In recent years, hospitals have absorbed much of the burden of federal deficit reduction. Further cuts of this magnitude are a direct threat to hospitals' ability to maintain access to the high-quality care Medicare beneficiaries and others expect and deserve.

Of $21.9 billion in proposed overall budget cuts below current-law levels for FY 1990, hospital payment reductions would constitute over 15.5 percent, while Medicare hospital payments comprise just over 5.4 percent of federal outlays.

While the budget plan contains a welcome and long overdue expansion of Medicaid services for poor and near-poor women and infants, the Medicare proposals seem more driven by a desire to reduce federal outlays than a commitment to fulfill the promise of providing access to high-quality health care services for the nation's elderly.

The AHA believes there should be no further cuts in Medicare payments to hospitals. Furthermore, additional funds are needed to improve the adequacy and equity of Medicare prospective payments.

It is essential that Congress demonstrate its commitment to Medicare by rejecting the Administration's proposed cuts. Similarly, making good on the promise of expanded access to needed medical care for the nation's poor and uninsured requires a commitment to both expand Medicaid eligibility and to place the program on a sound fiscal footing.

Mr. Chairman, my name is Thomas W. Chapman and I am the President of the Greater Southeast Community Hospital, Inc. here in the Dictrict of Columbia. On behalf of American Hospital Association's (AHA) nearly 5,300 member hospitals, I am pleased to present testimony on issues related to Fiscal Year (FY) 1990 budget proposals affecting the Medicare and Medicaid programs.

Trends in Medicare

The past five years have seen substantial reductions in Medicare funding. Despite these reductions, hospitals have struggled to maintain their commitment to delivering high-quality care for the nation's elderly and disabled. Quality and access have been maintained, but both are threatened by further cuts.

While several studies document the magnitude of these reductions, we believe it is generally fair to conclude that hospitals have indeed contributed more than their fair share toward efforts to reduce the federal deficit. The most recent study on the matter, published in the New England Journal of Medicine last week, concluded that Medicare payments for inpatient hospital care in 1990 will be about $18 billion lower than they would have been had trends prior to implementation of the prospective payment system (PPS) continued.

Unfortunately, the Administration's proposed budget calls for further reductions in payments to hospitals as compared to current law. The combined impact of these proposals would be a more than 5 percent reduction in payments for inpatient care, as well as an equally large reduction in payments for outpatient care beginning in FY 1991.

This pattern continues under President Bush. Assuming the Bush budget conforms with the final Reagan budget, for FY 1990 it will recommend Medicare hospital payment policy changes that would result in reductions of $3.4 billion below current-law estimates. Of the Bush Administration's $21.9 billion in recommended total budget cuts, Medicare hospital payment reductions would constitute over 15.5 percent of the total, even though such payments comprise just 5.4 percent of total federal outlays. Moreover, the effects of the entire Medicare budget proposal would result in $42 billion in additional cuts below current-law from FY 1990 to FY 1994.

Since 1985, the annual increase in prices under the PPS has been held to a level less than inflation. Moreover, continued uncertainty over payments under PPS has already seriously reduced the ability of hospitals to manage their resources effectively and efficiently --the two primary goals of PPS.

Since we still do not know the details of the new Administration's budget, we can only assume they mirror those proposed in the last Administration's FY 1990 budget. If so, they would include:

-- a 1.5 percentage point reduction in the annual update to the standardized rate for inpatient hospital services--that is, market basket minus 1.5 percent;

-- a 25 percent reduction in capital payments;

-- a reduction in indirect medical education payments of 47 percent; and

-- a 5 percent across-the-board reduction in outpatient payments beginning in FY 1991, growing to a 12 percent reduction in FY 1994.

Medicare Hospital Payment Outlays

Exclusive of benefit expansions in Medicare catastrophic coverage law, Medicare spending for inpatient hospital care under current law is projected to increase about 11 percent in FY 1990. But that 11 percent growth is the result of the following four factors: inflation in prices of goods and services used by hospitals; increases in the size and average age of the Medicare beneficiary population; a more seriously ill patient population; and expiration of certain payment reductions in effect during FY 1989.

Specifically, the Administration's budget assumes a hospital market basket increase of 4.7 percent; population growth and aging account for a 3.2 percent growth in outlays; the Medicare case-mix index (a measure of the complexity of Medicare hospital cases) is projected to rise about 1 percent; and the expiration of the current 15 percent reduction in capital payments will increase per-case payments 1.9 percent.

All the factors cited above are beyond the control of hospitals; nevertheless, the Administration's budget essentially requires hospitals to absorb the bulk of their impact. Despite an aging and growing beneficiary population that is more seriously ill, and more difficult to treat, hospitals would be expected to provide care next year at an aggregate expenditure level just about equal to this year's after controlling for inflation.

Unfortunately, the nation's hospitals simply do not have the reserves to do this. Such reductions would threaten directly both access to and quality of hospital care. Some hospitals would be forced to close their doors entirely, others to shift the burden to other payers, and still others to eliminate certain specialized but very costly services, reduce the hours of operation for some departments, lengthen the time patients must wait for nurses, or take other actions that compromise the availability and quality of care that we, as Americans, have come to expect of our health care system.

Impact of Cuts

Our current projection is that in FY 1990, payments by Medicare to the average hospital will fall short of costs by between 8 and 9 percent. Nearly two-thirds of all hospitals will lose money caring for Medicare patients, nearly half will incur deficits of 10 percent or more, and nearly 30 percent will incur losses of 20 percent or more. These projections are practically the same for urban hospitals, rural hospitals, teaching hospitals, and non-teaching hospitals. It is against this background that the Administration's proposals to reduce hospital payments $3.4 billion must be weighed.

There are two primary reasons for declining hospital margins: payment reductions in every budget reconciliation bill enacted by Congress since PPS' inception, and rising costs. The "bottom line" is that the combination of less-than-inflation updates in prices and higher-than-market-basket increases in costs has caused payments by Medicare to fall far short of the cost of caring for Medicare patients.

In addition, indirect medical education (IME) payments have been curtailed sharply. Since 1984, changes in the indirect medical education payment formula have cut these payments between 30 and 40 percent, depending on the level of involvement of the hospitals in graduate medical education. These reductions translate into reductions in aggregate PPS-related payments to teaching hospitals of between 2 and 12 percent. Although teaching hospitals were singled out by the Inspector General of the Department of Health and Human Services in the first year of PPS as having Medicare operating margins substantially above the average, that situation no longer prevails. Teaching hospitals are, on average, no better off than hospitals generally, and some are even experiencing larger deficits than non-teaching hospitals.

Any further reduction in the indirect adjustment would jeopardize the financial status of many teaching hospitals whose IME payments comprise an average 20 percent of their total Medicare payments. Moreover, while margins have declined for all hospitals in FY 1988, teaching hospital margins have declined an average 67 percent from FY 1987 to FY 1988. Reductions in the adjustment for teaching hospitals would force them to make substantive changes in the services they offer and the resources they use.

Further exacerbating the economic pressures on hospitals are a variety of other deficit reduction measures enacted over the years, measures that have affected everything from capital to outpatient payments.

Causes of Rising Hospital Costs

Many have argued that hospital margins would not have plummeted if hospitals had kept their costs under control. But there are legitimate reasons for hospital cost increases, which are directly associated with the very real demand for patient care and services and are beyond the control of hospital managers.

Health care is a unique product, and neither the provider nor the recipient is prepared to compromise on quality. Simply put, we all want and believe we deserve the best care possible. More specifically, there are several reasons for hospital costs rising above the Medicare market basket:

-- First, hospital costs are rising more rapidly than the Medicare market basket because the market basket fails to reflect accurately the increase in costs of the most important resource used to care for patients--the hospital's staff. Many types of hospital personnel are in short supply--particularly nurses, who typically comprise about one-half of total staff. As a result, hospitals must provide more rapidly increasing wages and benefits than offered to employees in other sectors of the economy. Nevertheless, Medicare bases its measure of "inflation" on changes in wages in other parts of the "private sector." The use of price proxies instead of an actual assessment of labor costs may understate the rate of hospital input price inflation by 2 to 4 percentage points.

-- Second, patients admitted to hospitals today are more seriously ill and require more complex treatment than patients admitted in 1984. Many "short stay" procedures have been moved outside the hospital. Treating more severely ill patients in the hospital requires a higher skill mix of employees. It is reasonable to project that this phenomenon accounts for an additional 2 to 4 percentage point increase in costs beyond inflation.

-- Last, advances in medical technology, which offer patients the hope of receiving less-invasive treatment and thus reduce pain and risk, significantly add to the per-case cost of treating hospital patients. The demand for more sophisticated tests and procedures has increased dramatically as consumers become aware of scientific advances. These costs are not always reflected in the measure of inflation used by Medicare.

Despite these pressures, hospitals have made efforts to increase productivity and contain costs. In fact, hospital productivity has increased significantly since the inception of PPS. Specifically, the number of full-time equivalent staff per adjusted admission has remained constant since 1984, despite increases in the acuity level of cases in both inpatient and outpatient settings. And hospitals continue to make every effort to improve efficiency in both the use of services and delivery of care. The evidence for these efforts is found in shorter lengths of stay and successful efforts to hold the line on increased staffing despite the admission of more patients needing more intensive care.

RECOMMENDATIONS

General Comments

Many individuals and entities involved in health care policy continue to debate the future direction of the health care system.

The AHA hopes that in addressing the nation's immediate concerns about the deficit, the new Administration and Congress will give more careful consideration to the long-term consequences that yearly budgetary decisions are beginning to have on the delivery of health care services.

In light of the fact that the Medicare hospital insurance program is financed by a dedicated payroll tax, we seriously question the advisability of using outlay reductions in this program as a tool for temporarily increasing Hospital Insurance Trust Fund surpluses, so that they may be used to mask the deficit being run in the unified budget.

Changes in both the Social Security and Medicare programs should be based on sound policy considerations rather than on short-term budgetary strategies. To ensure that Medicare payment policy issues are decided on their merits, the AHA believes that the hospital insurance program should be immediately removed from the unified budget and exempted from sequestration under the Gramm-Rudman-Hollings deficit reduction law.

As you know, development of PPS was a major policy reform enacted in the early 1980s with the support of the hospital field. However, since then, hospital payments have been significantly reduced, largely because of the deficit reduction imperative. It is clear that decisions are no longer being made in accord with the original goals of the program.

Implementation of PPS and its transition to national payment rates have resulted in a redistribution of Medicare hospital payments. When this system was created, it was widely acknowledged that there would be problems down the road, problems inherent in the reshuffling of any payment system involving the distribution of tens of billions of dollars.

Unfortunately, as a result of the deficit dilemma, efforts to address these problems have been implemented in a budget-neutral manner, which often means robbing Peter to pay Paul. For example, urban hospital payments have been reduced to increase rural hospital rates, and teaching hospital payments have been reduced to increase rates paid to hospitals serving large numbers of low-income patients. These changes were effected more easily in a budget-neutral manner in the early years of PPS when most hospitals experienced positive operating margins, but we simply cannot continue to operate under these circumstances when nearly two-thirds of the hospitals in the nation are losing money every time a Medicare beneficiary walks through their doors.

In short, we believe that there should be no further cuts in Medicare payments to hospitals. Moreover, it is our view that additional funds need to be provided to improve the adequacy and equity of payments under PPS.

Therefore, for FY 1990 we urge that proposed reductions in both capital payments and the indirect medical education adjustment be rejected. Moreover, we believe that all hospitals should receive, at a minimum, a full market basket update to their PPS rates.

Specific Proposals

Adequacy of Payment

Over time, Medicare payments to hospitals must bear a reasonable relationship to costs incurred in providing needed medical care to patients. To achieve this goal, the AHA recommends that payments be recalculated periodically based on current cost data. The Association believes that such a recalculation should include a recognition of costs associated with providing care to the medically indigent, as well as an appropriate level of funding to underwrite the risk experienced by hospitals under a fixed per-case payment system.

Rates should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of goods and services that hospitals must purchase to provide care. For providers exempt from PPS, a more timely means of adjusting payment limits of individual providers for change in case mix and treatment is needed.

This recommendation is a significant change in the Association's position. While we have categorically rejected previous attempts to "rebase" the system that were driven solely by deficit reduction demands, our current position is

based on a recognition that an objective standard is needed for judging whether PPS rates are adequate. Since the Prospective Payment Assessment Commission (ProPAC) and Congress have implicitly relied on hospital operating margins as the standard for judging adequacy, adopting this position would simply make that standard explicit.

Such an approach would provide hospitals with payment predictability--a fundamental principle that was promised when PPS was instituted--to allow hospital managers to undertake financial planning necessary to operate their institutions efficiently.

Because payments to individual hospitals would not be linked to their own costs but to changes in aggregate or system-wide costs, incentives for individual hospitals to improve efficiency would be preserved.

Equity Improvements

Nearly every reconciliation bill includes provisions that attempt to improve equity. These have ranged from addressing the problems experienced by hospitals that serve high volumes of low-income individuals to the special problems faced by rural hospitals. We view our recommendations as a systematic approach to build on the efforts undertaken by Congress and the Administration.

Our equity proposal includes four basic elements:

First, we recommend establishment of a single base rate, adjusted for differences in the kinds of patients admitted to hospitals and for differences in the prices hospitals must pay for resources.

However, our support for this approach is contingent upon two factors:

- o the single base rate should not be implemented without refined adjustments for patient mix and resource prices that are described below; and

- o movement to a single-rate system must be accompanied by a "hold-harmless" provision that protects hospitals from a reduction in payment resulting from movement to the single rate. In other words, we cannot support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments.

Second, the diagnosis-related group (DRG) system has been widely criticized for its failure to capture the "severity" of a patient's condition, and while we believe that a comprehensive severity adjustment should eventually be implemented, none of the current systems has reached a state of development and validation that would warrant its adoption. Until such a system can be embraced, a program of DRG refinement should be adopted. Efforts should focus on refinement of "problem" DRGs, which account for more than 1 percent of Medicare admissions and which show substantial variation in costs.

Third, PPS rates are currently adjusted only for differences in prevailing wage levels. In the long term, we believe that a comprehensive adjustment should be developed that accurately reflects prices paid by hospitals in local markets for all types of resources. In the interim we propose:

- that the existing wage index should be updated to reflect current wage levels;
- regional differences in liability insurance and energy costs should be adjusted for; and
- an exceptions and appeals process should be created to correct payment problems that are clearly beyond the control of hospital management and medical staff.

In fact, in both the long and short term an exceptions or appeals process will always be needed to take into consideration unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments assume that hospitals are "average" and will continue to work well for a majority of hospitals. But some hospitals will simply not fit into such a system of averages.

Fourth, given that small rural hospitals may lack the volume that is essential to a payment system based on averages, rural hospitals that operate fewer than 50 beds should be given the option to receive cost-based payments. In addition, criteria should be developed that would permit larger hospitals, including selected urban hospitals that are the sole source of care for their communities, to seek and receive an exemption from PPS.

Finally, we recommend other changes related to PPS that include refinements in payments for sole community providers and an extension of current payment policies for rural referral centers.

The Medicaid budget

The last Administration proposed a $1.7 billion reduction in Medicaid expenditures to be achieved through reductions to states in federal matching funds, the application of more restrictive eligibility criteria, and other miscellaneous measures. The Bush Administration now proposes merely to continue Medicaid expenditures in FY 1990 and beyond at the "current services" level.

Although some of the provisions of the Reagan Medicaid proposals have been carried over, including cuts in special administrative matching funds to the states, the Bush Administration proposes a substantial increase in eligibility. Specifically, mandatory eligibility would be added for pregnant women and infants who have family incomes up to 130 percent of the federal poverty level. This expansion in eligibility is long overdue and will address the needs of possibly 150,000 uninsured Americans.

The change in philosophy between the Reagan proposals and the proposals of President Bush is welcome. By the early 1980s Medicaid covered less then half the population living below the federal poverty level. Hospitals, through the privately insured patients they cared for, financed the social safety net that made needed medical care available to the nearly 37 million uninsured

Americans. The Administration's proposal builds on Congress' mandate to improve Medicaid coverage for pregnant women and infants. Members of Congress have already responded to President Bush's interest in this area and proposed legislation to phase-in expanded eligibility for pregnant women, infants, and chidren (S.339, H.R.800, H.R.833) and to require coverage for technology dependent children (H.R.832). The AHA strongly supports these legislative initiatives as important measures to assure access.

The silence of the Bush Administration on the question of how expanded eligibility will be funded is troubling, however. Reductions in federal administrative matching funds to states at the same time they are being asked to enroll a larger number of people may lead to further reductions in provider payments. Providing an entitlement to services without making sure that those providing the care are able to deliver it is an empty promise. It is essential that Congress ensure adequate funding is provided to fund high-quality health services for Medicaid populations. The AHA has joined a broad-based coalition, including providers, labor, and social service groups, calling on Congress to increase Medicaid funding to support needed programmatic reforms.

Conclusion

The priority health policy issue facing the nation is how to reconcile the need and demand for access to the highest quality medical care with the nation's limited resources. For Medicare, this means putting the program on a financially sound footing and ensuring the effective and efficient use of the program's resources without compromising quality. For Medicaid, this means finding a way of adequately funding access to services for the nation's poor and uninsured who are unable to purchase private health insurance coverage.

Reductions in payment that have been proposed by the Bush Administration would seriously compromise the ability of hospitals to maintain access to essential, high-quality medical care for Medicare beneficiaries.

Making sure that all Americans have access to care should be the fundamental goal of Medicaid. A minimum national eligibility floor for Medicaid would assure such access for the nation's neediest individuals. The President's interest and Congress' initiatives in eligibility expansion are important steps toward this goal. Other reforms are needed in the areas of enrollment incentives, financing, reimbursement, and coverage policies. The AHA will continue to work with Congress to address these much-needed reforms.

For both programs, a stable and reliable funding mechanism must be in place to fulfill the promise of health care services to the poor, disabled and elderly.

Although AHA recognizes the importance of reducing the federal deficit, we believe hospitals have already contributed disproportionately to the effort. A significant effort is needed to make Medicare and Medicaid more fiscally reliable and to make the reforms that will ensure adequate payment and equitable treatment both for hospitals and program beneficiaries. The AHA has recommended several actions that can be taken to achieve those goals and looks forward to working with the Congress in an effort to assure access to high-quality, cost-effective medical care for all Americans.

Chairman ROYBAL. Thank you, Mr. Chapman.

It is my understanding that Ms. Johnson has a closing statement. If not, I will start asking just one question, and then I would like to pose a question for each one of you that will be submitted to the Committee in writing.

Anything that you have, Ms. Johnson?

Ms. JOHNSON. Mr. Chairman, I would appreciate the opportunity to talk for a moment or two about poor children and uninsuredness.

Chairman ROYBAL. If it is going to add to what we have already heard, the Chair would be glad to recognize you.

Ms. JOHNSON. I believe it will.

Chairman ROYBAL. Thank you.

Ms. JOHNSON. We know that by 1986, nearly one out of every three poor children was completely uninsured and that figure translated into about 4 million poor children that year.

We also know that just over half of near poor children had private employer-based health care coverage, and for those near poor families, only about a third of insurance premium costs were covered.

That makes Medicaid coverage for children extremely important. We know that the delivery of care to those children and to the pregnant women who are going to deliver those children into those families, is extremely important; that we can save money by investing in those families.

We have made great leaps in the past 4 or 5 years in expanding Medicaid coverage to pregnant women and children. However, we know that further steps must be taken this year if we are to move forward toward finishing that job. We have covered some of the poorest and youngest children, but we have millions of children who are left outside of the system today.

Further incremental steps need to be taken by Congress and we really appreciate your sponsorship of legislation that has been introduced to further close the gaps by: mandating Medicaid coverage for near poor pregnant women and infants; expanding Medicaid coverage for all poor children; and making administrative reforms that we think will make these Medicaid eligibility expansions meaningful to families.

I appreciate the importance of the work that is going on on the Floor as well. C.D.F. has three institutional priorities this year, Medicaid, the minimum wage, and improving child care for families. Thank you.

Chairman ROYBAL. Thank you, Ms. Johnson.

The one question that I would like to have you answer is based on the testimony we heard today. That testimony is the administration's position, while it was not completely clear to me what that position is, a statement was made that a reduction of $5 billion would have a minimal adverse effect on the beneficiary.

I would like you to answer that question. What effect will a $5 billion reduction have on the beneficiary? Elaborate on that in writing for the Committee.

I will also hand you before you leave a list of any where from three to four questions that will be asked of each and every one of

you. I would like to have you answer those questions again in writing so we can really establish a record that is meaningful.

These questions, of course, are all very important. There will be other questions that will be submitted by other Members of the Committee. However, we are not going to hold this open forever.

If there are any questions that any other Member of the Committee is requesting to be answered in writing, it should be made available to you today.

I would like to thank each and every one of you for your testimony, and ask you to answer these questions no later than a week from today.

In other words, the record will be open for 1 more week. I hope there is a time when we can revisit this subject. I am not satisfied that in today's hearing we got all of the answers or even all of the proposals or the programs that could be put in place to remedy the situation.

In reading the testimony and questions, I find that generalizations are made. I think the purpose of the Committee is to focus more precisely on the net effect of the existing programs, of changes that are needed, and how the beneficiary would eventually be benefited by such a change.

I do not know that we can accomplish all of that, but we are going to try.

Again, I would like to thank you, Ms. Johnson, Mr. Chapman, Ms. Dixon, for your testimony this morning, and we stand adjourned until we meet again.

Thank you very much.

[Whereupon, at 3:30 p.m., the hearing was adjourned.]

APPENDIX

AARP

April 4, 1989

The Honorable Edward R. Roybal
Chairman
House Select Committee on Aging
Room 712, House Annex 1
Washington, D.C. 20515

Dear Mr. Chairman

This letter is to respond to the written questions you submitted following the March 23, 1989 hearing concerning proposed budget cuts in Medicare.

1. Re: The Part B Premium

As we discussed in our statement, AARP does not support the proposed extension of the requirement that premiums equal 25 percent of program costs. Beneficiaries want to pay their fair share of Medicare costs. However, beneficiaries have no control over this liability.

Premiums have increased over 91 percent since 1984. Beneficiaries also paid over $7 billion in coinsurance in FY 1988. It is important that cost containment efforts be achieved.

2. Re: Impact of Proposed Budget Cuts

It is impossible to state the exact impact on beneficiaries of the proposed budget cuts. Our written statement outlines several possible impacts.

First, in Part A, the Bush Administration proposes severe and immediate reductions in payments for capital and medical education. Cuts of this magnitude will threaten the viability of hospitals serving the poorest and the richest patients. While some reductions may be warranted, we must insure that we do not reduce access to care for less mobile persons.

Second, in Part B, we know from the past that price reductions have not achieved the savings expected because of increases in the number of services delivered. We have not yet addressed the volume side of the equation. When volume increases, beneficiaries and the U.S. Treasury pay more for Part B. The Association supports reductions in overpriced procedures with some investment of the savings towards primary care and other undervalued services.

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Louise D. Crooks *President* Horace B. Deets *Executive Director*

3. Re: Health Budget Priorities

The Association views providing health coverage for the 37 million uninsured and long term care for all Americans as two goals which can be worked towards simultaneously. These goals are not exclusive of each other.

The uninsured -- including the 12 million children uninsured -- need access to acute care services. This infrastructure is in place. We as a nation must simply decide how we are going to pay for these services. Ultimately society bears these costs; the choice is whether we do so in a fair and rational manner or not. We must decide the most appropriate way in which to pay for these services.

Long-term care however, has no structure by which services can be delivered in place at the current time. This structure must be developed and put in place. I would like to stress that long-term care in our view is not just for the elderly. Long-term care should be available to all persons who need such services.

It was a great opportunity to testify before your committee. The Association looks forward to working with you on these issues in the future.

Sincerely,

Margaret A. Dixon

Margaret A. Dixon
Member, Board of Directors

Children's Defense Fund

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Telephone (202) 628-8787

March 30, 1989

The Honorable Edward R. Roybal
Chairman, Select Committee
on Aging
House Annex 1 Room 712
Washington, D.C. 20515-6361

Dear Chairman Roybal:

Thank you for the opportunity to testify before the Select Committee regarding Medicaid Budget priorities in the 1990s and their effect on the health of children. We appreciate your continued committment to an intergenerational approach to funding priority discussions.

Enclosed you will find responses to the written questions I received the day of the hearing. The questions were excellent. I hope that my reponses, along with my oral remarks and printed testimony, will be included in full in the hearing record.

Again, thank you for your interest and concern in children and young families. Your support for preventive investment is crucial to our success in raising the next generation.

Sincerely,

Kay Johnson, M.P.H., M.Ed.
Director, Health Division

Enclosure

KJ:me

1. Ms. Johnson, as a representative from the Children's Defense Fund, do you believe that States will be able to pick-up the Bush proposal for Medicaid expansion or will the States just cut back in some other critical area of Medicaid?

Mr. Chairman, we are pleased that President Bush has proposed eligibility expansions for low income pregnant women and infants. In addition, the President's budget rejects former President Reagan's proposal to reduce Medicaid program expenditures by more than $1.5 billion in FY 1990. However, as a representative of the Children's Defense Fund, I am troubled by several elements of the President's Medicaid budget proposal.

Overall, the Adminstration's proposal includes only the funds needed to maintain the Medicaid program at current service levels. In order to offset the cost of proposed maternal and child health expansions, the President would reduce the federal medical assistance percentage paid for certain adminstrative activities that currently are matched at an enhanced rate (e.g. Medicaid Management Information System (MMIS) operations, nursing home pre-admission screening, etc.). States would lose $350 million in federal funds at the same time they would be required to expand coverage.

Currently, the Medicaid program has overhead costs of only 3 to 6 percent (an excellent ratio). Moreover, solid management systems, with special features such as nursing home pre-admission screening, contribute to the cost-effectiveness of states' Medicaid programs. Given these considerations, it is unclear why the adminstration has called for a squeeze on administrative budgets.

However, it is clear that cuts in administrative matching rates would be likely to have a negative effect an state's programs. In the face of new coverage mandates and cuts in budgets, states might be forced to consider adjustments in the amount, scope, and duration of benefits or to reduce optional coverage for groups such as older children.

2. Ms. Johnson, wouldn't you agree that all poor people, especially children should be covered by Medicaid in the next four years?

As my testimony documents, growing numbers of children have no health insurance public or private. Medicaid, as the state and federal program intended to serve the poor, should provide coverage to all uninsured children living in low income families. The Children's Defense Fund's preventive investment agenda for the 1990s calls for the following action:

o Beginning this year, and continuing over the next four years, Congress and the President should finish the job of Medicaid expansion by extending coverage to all pregnant women, infants, and children younger than 21 with family

incomes below 200 percent of the federal poverty level.

CDF estimates that these expansions would cost less than $2 billion per year when fully implemented. The Congressional Budget Office has estimated that the FY 1990 cost for the next incremental steps toward this goal would be approximately $ 340 million.

Adequate health care coverage is essential for all low income families. It allows for opportunities to use cost-effective preventive and primary care, as well as protection against the cost of catastrophic illness and disability. Children and pregnant women are among our most vulnerable populations, and must be assured access to care. Of course, their coverage is only the first step toward adequate coverage for all poor Americans.

Last month, the Health Policy Agenda (HPA), a coalition of 172 public and private sector groups representing health care providers, business, labor, consumers, government, and health policy experts, released a landmark report calling for a reform of the Medicaid system. Advocated reforms included the following:

- Medicaid should be restructured so that it is governed by national standards on eligibility rules, benefits, and provider reimbursement rates.

- Eligibility for Medicaid should be set at the federal poverty level for all individuals, without regard to family composition or health status.

- A federally mandated standard package of benefits should be provided in each state.

- Reimbursement rates should be set at adequate levels to encourage more providers to treat Medicaid patients.

- The Medicaid program should undertake measures to promote cost-effectiveness.

In terms of new spending, the Health Policy Agenda estimates that it would take $2.3 billion to expand eligibility to cover all the poor, $4.4 billion to improve provider reimbursement, and $6.5 billion to improve benefits.

This year, Congress could make a substantial down payment on these important reforms for all poor Americans through investment of $2 billion for improvements in Medicaid.

3. Ms. Johnson, what should be done to enhance provider participation in Medicaid, to assure there is access to health care for this Nation's poor children?

As early as 1970, studies of Medicaid found that low fees,

adminstrative red tape, discontinuous coverage, the indemnity nature of the program, and the programs's limited range of benefits reduced providers' willingness to participate in the program. As a result of these problems, relatively few private providers are willing to participate in the program and those that do frequently accept Medicaid patients only on a limited basis.

There are a number of ways in which this situation could be changed for the better. States should act to reduce administrative barriers for prompt provider reimbursement. Adoption of recent eligibility expansions and those now under consideration can translate into more continuous coverage for recipients. States also should set provider reimbursement rates at a level adequate to attract a sufficient supply of appropriate providers.

For publicly-funded providers, low reimbursement levels and delays in payment create an enormous strain. These providers generally have an obligation to furnish health care to the poor and consequently must devise strategies for survival with many "no-pay" patients and many other "inadequate-pay" patients with Medicaid coverage. Low reimbursement rates for community and migrant health centers, as well as clinics funded through the Title V Maternal and Child Health Block Grant, threaten to our public health service delivery system and reduces access to care for medically indigent families.

Inadequate Medicaid reimbursement undermines the capacity of such clinics to serve both Medicaid patients and millions of other low income, completely uninsured women, infants, and children. Appropriations for such programs must be set at a level adequate to meet the growing need among our most vulnerable populations. In addition, public clinics should be reimbursed by Medicaid at a level sufficient to cover the reasonable costs incurred for services furnished to Medicaid patients.

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March 30, 1989

The Honorable Edward R. Roybal
Select Committee on Aging
712 House office Building Annex I
Washington, DC 20515

Dear Representative Roybal

Thank you for inviting me to participate in the March 23 Select Committee on Aging hearing on "Medicare and Medicaid Budget Priorities in the 90's." I was pleased to represent the American Hospital Association and its nearly 5,300 member hospitals.

I am happy to respond to the questions you asked, but before I do so, I would like to set the record straight with respect to comments that Mr. Darman made earlier in the day. In his testimony Mr. Darman states that:

> "Since 1965, when Medicare was created, health care has been consuming an increasing proportion of our Gross National Product, from 6.0 percent of GNP in 1965 to 11.1 percent in 1986. Over the same period, the Federal government's share of national health care expenditures more than doubled, from 13 percent in 1965 to 29 percent in 1986. As a nation, we are spending more of our resources on health, and the Federal government has been assuming increased responsibility for allocating those resources among providers."

According to a recently published article in the New England Journal of Medicine, Medicare will spend almost 20 percent less in 1990 than had been projected before PPS. In addition, PPS has already substantially constrained Medicare outlays for hospital payments. In fact, hospital expenditures have remained virtually constant at 4.3 percent of GNP since 1982.

While we don't disagree that health care costs have increased dramatically over the years, we feel that it is generally fair to conclude that hospitals have thus far contributed more than their fair share toward efforts to reduce the federal deficit.

We strongly object to the continuing practice of using outlay reductions as a tool for temporarily increasing Hospital Insurance Trust Fund surpluses so they can be used to mask the deficit being run in the unified budget. Moreover, we fail to see how these year-to-year budget-driven policy decisions that underfund hospitals for the Medicare services they provide will help to reduce the costs of providing those services.

In his remarks, Mr. Darman also mentioned that costs under the Medicare program will grow nearly 11 percent in FY 1990. Exclusive of benefit expansions in the catastrophic law, Medicare spending for inpatient hospital care under current law is projected to increase about 11 percent in FY 1990. But that growth is the cumulative effect of the following four factors, which are beyond the control of hospitals:

- Inflation in the prices of goods and services used by hospitals (marketbasket), which accounts for 4.7 percent.
- Population growth and aging of beneficiaries, which accounts for 3.2 percent.
- Increased complexity of Medicare cases because of simpler cases being shifted to outpatient settings, which accounts for 1 percent, and
- Expiration of the 15 percent reduction in capital payments, which accounts for 1.9 percent.

If the Administration's Medicare budget proposals are adopted, outlays for inpatient hospital care will rise less than 5 percent, only marginally above the assumed rate of increase in the hospital marketbasket. That means that, despite a growing beneficiary population that is aging, more seriously ill, and more difficult to treat, the nation's hospitals would be expected to provide care next year at an aggregate expenditure level just about equal to this year's after controlling for inflation.

Now, with respect to your specific questions, I would add the following:

First, you ask what the direct and indirect impact will be on beneficiaries and the medically indigent if additional pressures are put on hospitals.

Let me just say that reductions of the magnitude proposed cannot be sustained over time without some corresponding erosion of quality or access to care. Cuts in the Medicare budget proposed by the Bush Administration further threaten both. Some hospitals would be forced to close their doors entirely, others to eliminate certain specialized but very costly services, reduce the hours of operation for some departments, lengthen the time patients must wait for nurses, or take other actions that compromise the availability and quality of care that we expect of our health care system. By curtailing services, pressure will mount to shorten lengths of stay, creating a burden for families and potentially increasing the readmission rate.

Furthermore, at a time when benefit expansions are being supported, there are fewer dollars available for these improvements or for continuing to provide free care to those targeted for increased benefits--women and children, for example.

Second, you asked if rationing would result from Medicare budget cuts.

Hospitals are unlike businesses; they fulfill an essential social function--the provision of health care to those in need. But hospitals' ability to meet that need is being undermined. Access to care is threatened if medically indigent patients must seek care in underfunded, overwhelmed public hospitals and clinics while those patients with private insurance have the freedom to choose their health care provider. Furthermore, shortages of health care professionals and inadequate funding, which translates to reduced services, marginal operations, and facility closures, also contribute to reduced access to quality health care.

As private insurance payments continue to tighten, Medicare is once again playing a significant part in the downward turn in hospitals' patient margins. These declining margins, coupled with proposed reductions in Medicare capital payments, will increase the cost of capital as bond ratings are continually downgraded. Medicaid also plays a part, with aggregate Medicaid payment shortfalls estimated to be in the billions of dollars.

The care delivery environment is not expected to change substantially in the near future. The AIDS epidemic shows no sign of abating; demand for highly skilled nurses continues to rise as the elderly population grows; and the severity of illness of hospital inpatients increases, necessitating intensified hospital services. In brief, opportunities to offset financial shortfalls with operational efficiencies are few indeed. As operating margins disappear and reserves diminish, the quality of hospital care is placed increasingly at risk.

Hospitals will, because of their mission, continue making every effort to provide quality services to those in need. We can only hope that the federal government's fiscal decisions don't result in policies that result in de facto rationing.

Third, you ask which types of hospitals are likely to close or cease to offer unprofitable but necessary services.

It is hard to predict what recourse many hospitals may have to weather this latest assault on operating revenues. We do know, however, that next year--even with no cuts in projected spending--nearly two-thirds of all hospitals will lose money caring for Medicare patients, nearly half will incur deficits of 10 percent or more, and nearly 30 percent will incur losses of 20 percent or more. These projections are practically the same for urban hospitals, rural hospitals, teaching hospitals, and non-teaching hospitals.

The system is increasingly fragile, and further reductions in payment levels under either Medicare or Medicaid will make it that much more difficult for hospitals attempting to provide care. For instance, any further reduction in the indirect medical education adjustment would jeopardize the financial status of many teaching hospitals, whose IME payments comprise an average 20 percent of their total Medicare payments.

In addition, hospitals need to be reimbursed for their actual capital costs. A majority of hospital capital spending is on renovation and modernization of hospital inpatient facilities, particularly on those built in the early years of the Hill-Burton program. Many of these hospitals serve a large percentage of indigent Medicaid and elderly Medicare patients. Reductions in capital payments would severely limit access to sophisticated lifesaving technologies.

In some urban areas, access to needed emergency and trauma care services is in jeopardy, as hospitals seek to further consolidate in the face of increasing budget restraints. In rural areas, many sole community providers are also being forced to cut services. The risk is that this "brownout" situation will, to build on Mr. Darman's analogy, spread like the PACMAN--eating up needed health care services in its wake. But hospital care is not a video game, and it will take more than a glib phrase and another roll of quarters to fix the system.

It is against this background that the Administration's proposals to reduce hospital payments $3.4 billion must be weighed.

Finally you ask what data the Administration and Congress need to collect to make better informed judgments concerning current and future budget proposals.

The Administration and Congress need to give more careful consideration to the long-term consequences that yearly budget decisions are having on the delivery of health care services. More up-to-date factual information would help lawmakers make more informed judgments about Medicare and Medicaid. For now, AHA would cite four areas that require special attention and further analysis:

1) The impact of significantly reduced PPS payments on the ability of hospitals to continue providing care to the elderly and disabled under Medicare. A better understanding of the "brownout" situation, in which medically necessary services are being reduced or eliminated, is needed.

2) A study of actual costs that hospitals face in acquiring and providing new technology. A better understanding of the correlation between rising costs of medical technology and demand is needed. With patients and physicians requiring state-of-the-art technologies, and capital sources drying up, hospitals are finding it increasingly difficult to finance either the purchase of new equipment or updating of existing equipment and procedures.

3) The Health Care Financing Administration needs to collect more current and accurate data to refine and update the area wage index under Medicare. Regional differences in liability insurance and energy costs are just some of the things that should be considered. Additionally, an exceptions and appeals process should be created to correct payment problems that are clearly beyond the control of hospital management and medical staffs.

4) Finally, more information is needed on the impact of the aging of the population and the costs incurred due to the increase in severity of patients being admitted to hospitals. The DRG system needs refinement so it can better reflect the multiple problems that seniors often face.

Sincerely

Thomas Chapman

Thomas Chapman
Greater Southeast Community Hospital, President
American Hospital Association Representative

AP

Statement of the American Medical Association

to the

SELECT COMMITTEE ON AGING

UNITED STATES HOUSE OF REPRESENTATIVES

RE: Medicare and the Fiscal Year 1990 Federal Budget

April 6, 1989

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Department of Federal Legislation
Division of Legislative Activities
(312) 645-4775

PRINCIPAL POINTS

Statement of the
American Medical Association

to the

Select Committee on Aging
United States House of Representatives

RE: Medicare and the Fiscal Year 1990 Federal Budget

April 6, 1989

Absent a determination to apply an across the board approach to freeze all federal spending, the AMA cannot endorse further cuts being made in the Medicare program. Additional cuts in Medicare will only exacerbate the problem of Medicare bearing a disproportionate share of federal budget cuts.

With the impact of massive legislative changes from past budget directed actions not even fully known, we strongly caution against further program changes that are aimed at achieving dollar savings as opposed to rational program improvement. Program changes imposed in the name of dollar savings also carry a real impact on our patients.

Recent statements in the press have pointed to the Part B side of Medicare as "the only place that hasn't experienced the crunch." Our experience is contrary and the facts are incontrovertible:

- Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. Relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health which published its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions.

At this point, we believe that the current Harvard study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. An issue that needs to be addressed in developing this payment schedule is mandated assignment under the Medicare program. With an indemnity payment schedule to exert stronger market controls on balance billing, and especially in light of the prevalence of claim-by-claim assignment, the AMA continues to oppose mandated assignment under Medicare. The AMA encourages physicians to take their patients' economic status into account and data show that they do. It also must be realized that limits on balance bills will pose a

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financial risk to the Medicare program. Studies on the effects of cost-sharing by the RAND Corporation and the Congressional Budget Office indicate that elimination of balance billing could greatly increase Medicare expenditures.

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a view that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. The truth of the matter is that physicians are not causing vast unnecessary program expenditures. Major factors leading to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;

- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and

- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

The American Medical Association acknowledges that appropriateness of care and volume of services are related. We do not believe that setting Medicare expenditure targets is an appropriate response to this issue.

- No matter how a proposal for expenditure targets is couched, the bottom line is that it is nothing more than a system of implicit rationing of health care to elderly and disabled Americans. The AMA vigorously opposes the concept of expenditure targets.

One potential and we think workable solution to help assure the provision of high quality care, with the potential side effect of program savings without the adverse consequences of rationing, is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate care. The AMA is taking the lead role in appropriateness initiatives through our Office of Quality Assurance and Assessment. We expect results on this project this year. The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

SELECT COMMITTEE ON AGING
UNITED STATES HOUSE OF REPRESENTATIVES

RE: Medicare and the Fiscal Year 1990 Federal Budget

April 6, 1989

The AMA is pleased to have this opportunity to submit this statement to the Committee and for the Committee's record from the March 23, 1989 hearing on "budget priorities for the 90s." This statement will focus on Administration proposals to cut up to $5.5 billion from the projected Medicare budget for fiscal year 1990.

As a starting point, the Medicare program has already been subjected to over a decade of major cuts. Further cuts will jeopardize our ability to provide necessary services to our elderly and disabled patients. It is time to stop trying to balance the budget on the back of the Medicare program.

The AMA appreciates the dilemma Congress faces. We understand that there is the compelling need to find substantial savings in a federal budget when the deficit is so immense that interest on the national debt is the third largest component of the overall federal budget. On the other hand, further cuts in the Medicare program -- the guarantor of health care coverage for over 33 million Americans -- will impair our ability as physicians and as a society to continue the promises of this program. In your deliberations, we urge you to apply an evenhanded approach. Absent a determination to apply an across the board approach

to freeze all federal spending, the AMA cannot endorse further cuts being made in the Medicare program.

Additional cuts in Medicare will only exacerbate the situation of having Medicare bear a disproportionate share of federal budget cuts:

> From 1980 to 1988, actual Medicare spending compared with Office of Management and Budget (OMB) projected current services spending shows that $7.9 billion was cut during this same period, and notwithstanding this sharp reduction in Medicare expenditures, total federal spending actually increased by $120.3 billion over OMB projected current services spending.

With the impact of massive legislative changes from past budget directed actions not even fully known, we strongly caution against further program changes that are aimed at achieving dollar savings as opposed to rational program improvement. Program changes, especially those imposed in the name of dollar savings, also carry a real impact on our patients.

At the outset, we challenge and want to dispense with the mistaken impression that physicians have been relatively untouched by past budget cutting actions. Recent statements in the press have pointed to the Part B side of Medicare as "the only place that hasn't experienced the crunch." Our experience is contrary and the facts are incontrovertible:

- Medicare reimbursement and fees were frozen for most physicians for 40 months from July 1983 to 1987;
- Medicare reimbursements for selected procedures were cut across-the-board by a total of 12% in 1987 and 1988, and special limits were imposed on physician fees for these procedures;
- The Medicare allowed amount for an office visit is only 73% of the amount actually billed by physicians to other patients (according to our 1986 survey); and

- Physicians presently are the only profession subject to federal price controls, the maximum allowable actual charge program.

Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A. (A summary of recent actions limiting physician reimbursement and charges is attached as Appendix I.)

Nevertheless, in a $90 billion program where approximately $25 billion was spent for physician services in 1988 (compared with $48 billion for hospital care in the same year), some savings can be found. If there is to be no across the board measure, and if it is decided that Medicare spending cuts are unavoidable, we believe that any Medicare reductions should be done in proportion to actual outlays.

Last month, the AMA's Board of Trustees considered the Medicare budget proposals set forth by President Reagan in his final budget submission. Our views on these issues are set out in the attached appendix (Appendix II). The issues which we feel essential to discuss in detail here are the overall issue of physician payment reform, Medicare assignment, the growing volume of Medicare services and expenditures, and Medicare expenditure targets.

Physician Payment Reform under Medicare

It is impossible to discuss Medicare Part B savings without also discussing future directions for physician reimbursement policy under this program. There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The fact that current physician reimbursement and payment levels are based on 1971 actual charges as their starting point and have been subjected over the years to a myriad of payment and fee controls illustrates why the system is fraught with inequities.

The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health which published its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The AMA believes that such a payment system could ameliorate many of the uncertainties inherent in current Medicare payments and ameliorate inequities. It also would provide patients with a greater understanding of the financial obligations for each service. The RBRVS study now is being analyzed by the Health Care Financing Administration, the Physician Payment Review Commission, the AMA and others.

At this point, we believe that the current Harvard study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. The AMA has

identified seven specific areas of the Harvard study that need additional work prior to its use in Medicare payment determinations:

- Restudy of specialties whose RBRVS data have significant, documented technical deficiencies;
- Fundamental improvement of the measurement of relative practice costs and specialty training costs;
- Expansion of the RBRVS to more specialties and services;
- Development of an extrapolation method for visits;
- Revision, refinement, and expansion of pre- and post-service work measurement;
- Expansion and validation of the current extrapolation method; and
- Development of relative value estimates for global surgical services as standard definitions are developed and accepted.

Much of the work necessary to complete and improve the RBRVS is underway in the study's second phase. As a study subcontractor, the AMA is participating actively with Harvard and a number of specialty societies in the process of expansion and refinement needed to produce a technically adequate RBRVS.

Medicare Assignment

The AMA applauds the decision of the Physician Payment Review Commission (PPRC) to not recommend mandated assignment under the Medicare program. (Mandated assignment would require physicians to accept the Medicare allowed amount as payment in full regardless of the excellence or unique nature of the services provided or the ability of the patient to pay the physician's regular charge for the service.) Medicare already substantially discounts physicians' fees. The gap between Medicare allowed amounts and physician's regular fees has grown from 10% in 1970 to the current approximate level of 27%. In otherwords, years of budget cuts

and regulation have left Medicare paying only 73% of physicians' regular fees. Nevertheless, physician acceptance of assignment has continued to increase to all-time record highs. The fact that close to 80% of charges for physician services are assigned demonstrates that physicians are responsible to their patients' situations.

In any discussion of mandatory assignment, it must be realized that the total a physician may bill a patient between the allowed amount and the maximum allowable actual charge represents only a small percentage of the total out-of-pocket expenses a Medicare beneficiary may experience. HCFA estimates average out-of-pocket costs of about $600 in 1987 per aged beneficiary for Part B services, balance billing amounts accounted for about only 18%; while co-insurance amounts accounted for approximately 32%, deductibles accounted for approximately 12%, and premiums accounted for approximately 38% of patient financial liability.

It is also important to note that physician balance billing and other beneficiary expense responsibilities do not represent a financial barrier to needed care. The data from the PPRC's beneficiary survey report that only 6.4% of respondents did not seek care during the previous year because of the cost, with only 3.1% putting off treatment for a serious condition. Only 0.2% reported being actually denied care for financial reasons (including deductible, co-insurance and balance billing). Although any delay in seeking treatment due to financial considerations is worrisome, these numbers do not suggest that balance bills exert a negative impact on access.

This record clearly demonstrates that physicians do care about their patients' economic circumstances and accept assignment a vast majority of the time. The AMA encourages physicians to take their patients' economic status into account and data show that they do. An Urban Institute study summarized evidence that physicians are more likely to assign claims in low-income areas. The PPRC's physician survey revealed that patients over age 75 were more likely to have claims assigned, and that claims are more likely to be assigned if the patient lacked supplementary insurance. Another PPRC analysis found that voluntary assignment rates were higher for poor patients than for better-off ones. Consider the following points from the PPRC surveys:

- For individuals with a regular source of care, the PPRC beneficiary survey reported that the voluntary assignment rate (excluding Medicaid) from the patient's regular physician was 56%, and 68% on the last visit with a specialist. The physician survey found that of non-participating physicians, 85% routinely accepted assignment for some of their patients, regardless of the service provided, and that 95% of these physicians consider the patients financial status in this decision.

- When beneficiaries were asked whether they were actually balance billed on their most recent bill, only 17% indicated that they had been, with those over age 85 and those below 200% of the poverty level least likely to have received such a bill.

- A PPRC analysis of 1987 data from eight states found that 3% of patients had annual balance bills exceeding $500, that 52% had no balance billing liability and 30% had balance bills of $50 or less. Even among those patients with more than $5,000 in annual Medicare allowed charges, the majority had $50 or less in balance bills.

Policy approaches that restrict or eliminate physicians' ability to establish their fees are not warranted. When one studies the distribution of balance bills and the actual amount of individual bills,

as the PPRC has, it becomes clear that there simply is not a large enough number of persons who are experiencing substantial financial problems from balance bills to justify mandating assignment or imposing stringent charge restriction for all Medicare beneficiaries.

Finally, it must be realized that limits on balance bills will pose a financial risk to the Medicare program. Studies on the effects of cost-sharing by the RAND Corporation and the Congressional Budget Office indicate that elimination of balance billing could greatly increase Medicare expenditures.

Expenditure Targets

One potential means to limit Medicare spending is the concept of expenditure targets. While the PPRC has called for Medicare expenditure targets, we believe that they would constitute a radical departure from our nation's commitment in creating the Medicare program to provide the elderly with all necessary medical and other acute health care. This concept would replace that commitment with an implicit system of economic incentives to withhold services to meet the expenditure target. In effect, it would call upon physicians to make the rationing decisions for society on a case-by-case, encounter-by-encounter basis.

The PPRC recommendation may appear to be a painless way to hold the line on program expenditures, but the bottom line of a decision to impose expenditure targets is the creation of an implicit system to ration health care. A national target, tied arbitrarily to a formula that depends heavily upon "a decision concerning the appropriate rate of increase in volume of services per enrollee" rather than actual health care needs, provides the starkest possible proof of this point.

In addition to our view that rationing is not an acceptable direction to reduce Medicare expenditures, the American people do not want rationing of health care for the elderly and disabled. Public opinion surveys consistently find that the American people want to cover the health care needs of these populations:

- In response to a 1986 poll conducted for NBC News and the Wall Street Journal, when asked: "To help reduce the federal budget deficit, would you favor reduced benefits for Medicare or not?... 86% answered that they opposed reduced Medicare spending.

- In response to a 1987 poll conducted for ABC News/Washington Post, when asked: "Should spending for (the Medicare program which helps reduce health care costs for the elderly) be increased, decreased or left about the same?"...only 3% called for decreased spending, 22% called for spending to stay the same, and 74% called for increased spending.

- In response to a 1988 poll conducted for NBC News/Wall Street Journal, when asked: "Do you want to see the federal government spend more or less money ...to provide health care for the elderly?"...only 5% called for less spending, and 83% called for more spending to meet the health care needs of the elderly.

Establishing a nationwide or regional system of expenditure targets eventually would devolve into a system that would mirror many of the same problems evidenced in those Canadian provinces (British Columbia, Alberta and Quebec) that limit total expenditures for medical and health services. With their experience as a model for what could happen in our country, there is mounting evidence that limiting program benefits through expenditure targets will result in medically unacceptable results.

As recently reported in the Canadian press, their health system is starting to deteriorate and rationing is now being openly discussed.

According to the Canadian weekly newsmagazine Maclean's (February 13, 1989) patients have died after long waits for needed surgery and elderly patients in Montreal hospitals are being kept in diapers because nurses do not have time to help them go to a bathroom. Other examples from these provinces present a telling story:

- The wait in Vancouver for psychiatric, neurosurgical or routine orthopedic consultation is 1 - 3 months, 6 - 9 months for cataract extraction, 2 - 4 years for corneal transplantation, and 6 - 18 months for admission to a long term placement bed.
- Many waiting lists in the province of Quebec for angiograms are six months long.
- The wait in the province of Quebec for coronary artery bypass surgery is 8 - 9 months.
- Montreal and Vancouver emergency departments often have no capacity to handle new patients.
- In all of Canada, there are only 11 hospitals that are capable of performing open heart surgery (793 in the U.S.), 14 hospitals capable of performing organ transplants (319 in the U.S.), and only 12 hospitals have magnetic resonance imaging (MRI) equipment (there are no MRI facilities outside of hospitals in Canada). [Canadian figures are from 1988 and U.S. figures are from 1987.]

Based on the Canadian experience, we do not believe that Congress should experiment on our elderly population with this type of proposal. Such a system is unprecedented in the United States and holds very real risks for our elderly and disabled patients. In the PPRC's testimony before the Senate Finance Committee, they recommended that target rates of increase for the first few years of using such targets "not depart substantially from baseline rates of increase." We applaud this prudent element of the recommendation by the Commission, and we believe that it

only proves our point regarding the substantial potential risks that expenditure targets pose for Medicare beneficiaries. We urge rejection of this approach.

Volume/Appropriateness and Quality of Care

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a perception that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. As a result of this perception, there has been growing interest in complex regulatory policies to achieve budget savings through controlling volume growth and reducing levels of unnecessary care. Although the AMA fully supports the elimination of unnecessary care --and we only wish that all of the needed savings could be generated by such a simple solution-- the truth of the matter is that physicians are not causing vast unnecessary program expenditures. Major factors leading to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;
- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

(A detailed analysis on this issue is attached to this statement as Appendix III.)

The American Medical Association acknowledges that appropriateness of care is directly related to the issue of volume. We believe that review of care, to be successful, must be based on physician-developed appropriateness criteria and on coverage decisions that preserve patient

access to quality medical care. When utilization management programs are not run properly, the provision of quality health care to program beneficiaries is compromised. Too often, reviewers with little or no clinical training are given authority to deny claims as "not medically necessary." As we have seen, some carriers actually deny claims on the basis of "screen failure" alone without necessary claims development.

One potential and we think workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Through our Office of Quality Assurance and Assessment, the AMA is pursuing its clinical appropriateness initiative with the RAND Corporation to develop practice parameters. The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians.

CONCLUSION

In conclusion, the AMA is very concerned over the potential impact on access to care if the history of arbitrary cuts in the Medicare program continues. The results of a 1987 physician survey into how physicians have changed their practice patterns as a result of Medicare program changes imposed since 1984 revealed that 22% of the physicians who regularly treat Medicare beneficiaries had taken measures that result in restricted access to care for their Medicare patients. According to this survey, physicians have reduced the number of or did not accept new Medicare patients; and/or have reduced the number of or did not perform

certain procedures for Medicare covered patients. In addition, the number of Medicare beneficiaries and their demands for care are growing at a faster rate than the physician population. Thus, if we see a continuation of program budget slashing, the potential for serious access problems occurring in the not so distant future must be a serious concern.

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APPENDIX I

Physician Reimbursement Restraints Under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for these services.

In 1969, prevailing charge levels were lowered from the 90th percentile to the 83rd percentile of customary charges. In 1970, prevailing charge levels were lowered to the 75th percentile of customary charges. For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charge levels. In 1976, the Medicare Economic Index (MEI) as used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

Starting with the Deficit Reduction Act of 1984 (DRA) further and substantial limits were imposed on physician reimbursement and charges for services provided Medicare beneficiaries. The DRA modified physician reimbursement in the following ways:

Two classes of physicians were created: "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (if no freeze had been imposed by the DRA, the economic index would have allowed a 3.34% increase of prevailing charge levels on July 1, 1984);

The scheduled July 1, 1984 increase in fee profiles was eliminated, and the future annual update in fee profiles was delayed from July 1 to October 1, with the next increase set for October 1, 1985; and

Fees for services provided Medicare beneficiaries by "non-participating physicians" were frozen during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

The Emergency Extension Act again froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86. Further legislation extended the Extension Act, with fee and reimbursement levels again frozen through March 15, 1986.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) yet again extended the Medicare reimbursement freeze: i) the freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986; and ii) the freeze in the customary and prevailing charge levels for participating physicians was allowed to end May 1, 1986, with the prevailing charge increase for participating physicians set at only 4.15%.

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) made substantial modifications in physician reimbursement and fee limits.

Reimbursement - Both participating and non-participating physicians were allowed an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. Beginning on January 1, 1987, prevailing charges for non-participating physicians were set at 96% of the prevailing charge levels allowed participating physicians.

Fees - The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by Maximum Allowable Actual Charge (MAAC) limits. Each MAAC is determined by a complicated formula applicable to every charge of every individual physician. Physicians are subject to substantial penalties for violation of MAAC limits. MAAC limits are determined as follows:

If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:

January 1, 1987 - charge increases were limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1988 - charge increases were limited to 1/3rd of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1989 - charge increases are limited to 1/2 of the difference between the actual charge and 115% of the Medicare prevailing charge; and

January 1, 1990 and subsequent years - actual charges may be increased to 115% of the Medicare prevailing charge.

OBRA-86 reduced prevailing charge levels for cataract surgery by 10% in 1987 plus another 2% in 1988. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Special limits on fees for these services also were imposed, with actual charges limited to 1/2 the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) made further substantial modifications in Medicare payment for physicians' services:

Three-Month Freeze - Prevailing and customary charge levels were maintained at the levels in effect during 1987 during the three-month period ending on March 31, 1988. Also during this three-month period, MAACs were kept at the amount determined for 1987. 1988 MAACs did not go into effect until April 1, 1988.

Sequestration - The Gramm-Rudman-Hollings sequestration reduced payments for physicians' services by 2.324% through March 1988.

Medicare Economic Index (MEI) - For services provided by participating physicians after March 31, 1988, the MEI increase was limited to 3.6% for primary care services and 1% for other physicians' services. Increases for the services of non-participating physicians were set at 0.5% less than the increase allowed participating physicians (3.1% and 0.5%). For physicians' services furnished in 1989, the increase for participating physicians is to be 3% for primary care services and 1% for other physicians' services. The increase in 1989 for non-participating physicians will be 0.5% less.

Reductions in Prevailing Charge Levels - The following physicians' services provided after March 31, 1988 were subjected to "reasonable charge" reductions: bronchoscopy (Codes 31622-31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830-66985), coronary artery bypass surgery (Codes 33510-33528), knee arthroscopy (Codes 29880-29881), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroplasty (Codes 27446-27447), pacemaker implantation (Codes 33206-33208), total hip replacement (Codes 27130-27132), suprapubic prostatectomy (Code 55821), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235-43239). The 1987 prevailing charge levels for these services initially were reduced by 2%. Further reductions of up to 15% were implemented according to a sliding scale formula for services between 85% and 150% of the national average.

Where a non-participating physician's allowed charge is reduced by the application of this provision (or for cataract procedures, or physician supervision of certified registered nurse-anesthetists), the physician may not charge the beneficiary more than 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level. In subsequent years, the maximum allowed charge will be set at 125% of the prevailing charge. Where a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions (civil

money penalties, assessments, and five-year barring) against the physician. These charge reductions will not apply to services furnished after the earlier of December 31, 1990 or one year after the Secretary reports to Congress on development of the RVS.

Payment for Physician Anesthesia Services - In determining the amount allowed for the medical direction of two or more nurse anesthetists (in which services are provided in whole or in part concurrently) for services provided after March 31, 1988 and prior to January 1, 1991, the number of base units recognized for the medical direction (other than for cataract surgery or an iridectomy) will be reduced from current levels by: 10% where the medical direction is of two nurse anesthetists concurrently; 25% where the medical direction is of three nurse anesthetists concurrently; and 40% where the medical direction is of four nurse anesthetists concurrently. Where the anesthesia services are for concurrent cataract surgery or an iridectomy procedure provided after December 31, 1989 and before January 1, 1991, the number of base units that will be recognized for the medical direction will be reduced from current levels by 10%.

Fee Schedules for Radiologist Services - Medicare payments for radiologist services will be the lesser of 80% of the actual charge for the service or the amount provided under a fee schedule. "Radiologist services" are defined to include radiologic services performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology, or a physician for whom radiologic services account for at least 50% of his or her Medicare billings.

Radiology Charge Limitations - Where radiologist services are provided by non-participating physicians or suppliers after 1988 and where payment is made pursuant to the fee schedule, the maximum amount that may be billed will be subject to a "limiting charge." The limiting charge will apply as follows: in 1989 - 125% of the amount specified in the fee schedule; in 1990 - 120% of the amount specified in the fee schedule; and after 1990 - 115% of the amount specified in the fee schedule. Where a charge is "knowingly and willfully" imposed above the limiting charge, sanctions may be applied

Limits on Payment for Ophthalmic Ultrasound - Effective for services provided after March 31, 1988, the prevailing charge level for A-mode ophthalmic ultrasound procedures may not exceed 5% of the prevailing charge level established for extracapsular cataract removal with lens implantation. Limits on actual charges for this service also apply.

Customary Charges for Services of New Physicians - For physicians who do not have adequate actual charge data, customary charges are to be set at 80% of the prevailing charge for the service in the area. (Previously, these charges were set at the 50th percentile of customary charges in the area, an amount usually above prevailing charge levels.) This limit is not applicable for primary care services or for services provided in designated rural areas.

December 15, 1988

PRESIDENT REAGAN'S FISCAL YEAR 1990 MEDICARE BUDGET PROPOSALS

The following pages set out the Medicare proposals contained in President Reagan's FY90 budget and the AMA's position on those proposals that are described in sufficient detail in the budget.

The Reagan Administration's federal budget for fiscal year (FY) 1990 requests $424 billion in outlays for the Department of Health and Human Services. This amount represents an increase in total outlays of almost $23 billion (5.7%) compared to current estimates for FY89. The largest component of the HHS budget is for Social Security outlays of $244 billion (an increase of about $14 billion, 6.2%, over estimated FY89 outlays).

The budget proposes nearly $3.5 billion in Medicare savings. Including these proposed savings, the projected outlays for the Medicare program are $94.9 billion (an increase of $8.1 billion, 10%, over the estimated FY89 outlays).

During the 1980s, the Medicare program has been subjected to numerous, arbitrary spending cuts. The AMA continues to be concerned that such cuts threaten the access to and quality of care for Medicare beneficiaries. The AMA opposes any additional arbitrary reductions in either Medicare Part A or Part B. In addition, the AMA continues to support certain revenue-enhancing proposals, including raising the Part B premium to 35% of program costs and requiring all state and local government employees to pay Hospital Insurance taxes.

Specific Medicare proposals set out in the FY90 budget proposal and the Association's views concerning each are set forth below.

Medicare Part B Proposals

1. Part B Premium (Revenues of $617 million in FY90)

   The budget proposes to extend Part B premium rates to cover 25% of Part B program costs.

   Position: The AMA continues to support increases in the Part B premium to fund at least 35% of program costs, noting that the Part B premium originally was to cover half of the program expenses.

2. Physician Payment: Reduce Payment for Certain Overpriced Procedures (Savings of $100 million in FY90)

   The budget proposes a reduction of up to 12% for 12 surgical procedures previously subjected to legislative reductions or other procedures that the Secretary may identify as overpriced. The 12 procedures subjected to reductions are: bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

Position: The AMA opposes these arbitrary cuts. Also, Congress has created a specific mechanism (inherent reasonableness regulation authority) to respond to inappropriate payment levels. The Association believes that all payment issues should be considered as part of a larger picture, such as the resource based relative value study now under way.

3. Reduce Physician Payment for Radiology, Anesthesiology and Surgery (RAS) Services (Savings of $250 million in FY90)

The budget proposes a reduction of 8 percent in payment levels for radiology, anesthesiology and surgery services, beginning in 1990.

Position: Payment levels should be determined through an indemnity system based on a Resource-Based Relative Value Study. In opposing this provision, the Association points to its arbitrary nature and the fact that recent payment cuts for radiology and anesthesiology services as well as limited MEI updates for surgical services have not been subjected to any analysis as to the effect of these cuts and limits.

4. Freeze MEI for Physicians' Non-Primary Care Services (Savings of $375 million in FY90)

By law, the annual increase in prevailing charge levels for physicians' services is limited by the Medicare Economic Index (MEI). The budget proposes a three-year update policy under which there would be no MEI increase in prevailing charges for non-primary care services of physicians in 1990, and a 1% increase in each of the next two years. Prevailing charges for primary care services of physicians would be increased by the full MEI in each of those years.

Position: While the AMA recognizes that primary care services generally have been under-reimbursed by Medicare, the AMA supports full and equal MEI updates.

5. New Physician Customary Charges (Savings of $40 million in FY90)

The budget proposes to phase in increases in customary charges for new physicians over four years: 80 percent of prevailing charge levels for first year physicians; 85 percent for second year; 90 percent for third year; and 95 percent for fourth year.

Position: The AMA previously opposed setting new physicians' customary charges at 80% of prevailing charge levels. The AMA opposes this new proposal as it only exacerbates the inequity of Medicare customary charges not reflecting real charges or expenses.

Part A Provisions

1. Direct Medical Education (Savings of $120 million in Part A and $30 million in Part B in FY90)

   The budget proposes that direct graduate medical education costs be limited to the costs related to residents' salaries and fringe benefits and appropriately allocated overhead costs. Program costs such as classroom space and supervision by teaching physicians would not be reimbursed.

   Position: The AMA supports Medicare continuing to reimburse its fair share of all appropriate direct medical education costs. Legitimate direct medical education expenses incurred for administration, physical plant, classroom space, and supervision by teaching physicians should not be ignored in determining the fair share of such expenses to be borne by Medicare. Separating the service from the education aspects of residency programs could disrupt the educational process.

2. Indirect Medical Education (Savings of $1.02 billion in FY90)

   The budget would reduce the indirect medical education adjustment from 7.7% to 4.05% in FY90.

   Position: The indirect medical education adjustment should not be reduced below 6.6% unless and until such a reduction can be justified by reliable statistical data and adequate assurances exist that such a reduction would not negatively affect the quality of care. The AMA is concerned over the impact on teaching hospitals of a significant cut in the indirect medical education adjustment.

3. Peer Review Organizations

   The budget requests $290 million for the PRO program, a decrease of $5 million from the FY89 funding level.

   Position: The AMA supports adequate funding for the PRO program, and the Association believes the funding level proposed is adequate.

4. Set the Prospective Payment System (PPS) Update at the Market Basket Minus 1.5 Percent (Savings of $625 million in FY90)

The budget proposes to set the PPS adjustment at 1.5% less than the full market basket. The FY 1990 market basket is currently estimated to be 4.7%.

Position: The AMA previously supported the concept in the original PPS law of allowing an annual increase of market basket plus 1%, with the 1% being for new technology. While the Association recognizes the need for savings from all sectors of the budget, the AMA cannot support an adjustment below the market basket based on the current economic condition of hospitals.

5. Reduce Capital Payments to Hospitals by an Additional 10 Percent (Savings of $620 million in FY90)

Current law provides for reductions of capital payments to hospitals under the PPS. From October 1, 1988 through September 30, 1989, payments for capital costs are reduced by 15 percent. This provision, however, expires after 1989. HCFA is proposing an extension of the FY89 payment rates and that capital payments be reduced by an additional 10 percent in FY90. Current law now requires that the Secretary incorporate payments for capital into PPS on a per-case basis, beginning in 1992.

Position: The AMA is concerned that inappropriate implementation of changes in capital reimbursement could have a severe negative impact on the ability of patients to receive needed medical services. Money not spent on capital improvements today could result in more expensive costs down the road. The AMA believes that any hospital capital cost proposal must be closely monitored to assure that institutions can properly provide needed services for patients, and that any such proposal must provide for an adequate transition to allow institutions to meet already committed capital cost obligations.

6. Include Under Medicare State and Local Employees Hired Before March 31, 1986 (Revenue Increase of $2,027 million in FY90)

COBRA mandated Medicare coverage and payment of Hospital Insurance taxes for new state and local government employees hired after March 31, 1986. The budget proposes making Medicare coverage and Hospital Insurance taxes mandatory for all state and local employees, including those hired before March 31, 1986.

Position: The AMA supports this provision which is intended to bring about universal Medicare coverage.

APPENDIX III

MEDICARE PART B EXPENDITURES
ANALYSIS OF GROWTH

INTRODUCTION

Part B of Medicare covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. Disbursements for the Part B program have been the fastest growing non-defense expenditure item in the federal budget in this decade, having increased an average 16.3 percent annually between 1980 and 1987.

Even after inflation in medical care prices has been taken into account, total real disbursements increased at a 7.4 percent average annual rate. Growth in the enrolled Medicare population of 1.9 percent per year accounts for only a small amount of the real growth. The "residual" component of the inflation-adjusted growth that is not explained by beneficiary demographics (5.5 percent) is broadly attributed to increases in "volume" of services per eligible beneficiary and to increased "intensity" of services; i.e. more services per visit.

This report concerns that residual component of outlay growth not due to price inflation or enrollee increase, with special emphasis on the underlying factors responsible for the growth.

COMPONENTS OF PART B OUTLAYS

An accounting adjustment gives a truer picture of cost growth in the Part B program. The usual practice of focusing on cost per enrollee overstates the growth in "volume and intensity" when the proportion of enrollees who actually receive services is also growing. Analyzing costs on a per enrollee basis results in confusing the increased number of users as part of the increase in volume per enrollee. According to the General Accounting Office, the number of persons served per 1000 enrollees increased by about 16 percent between 1980 and 1986 (United States General Accounting Office, 1988). This means that growth in real outlays per service recipient was 3.0 percent per year.

To better understand the nature of Part B expenditures, it should be kept in mind that:

- physician services are about 60 percent of total Part B allowed charges;
- outpatient hospital department (OPD) services are about 28 percent of total allowed charges; and
- OPD allowed charges grew an average of 30 percent per year compared to 13 percent for physician services from 1980 to 1986.

These figures show that outpatient hospital services are a substantial component of the Part B program and contributed more to expenditure increases than physician services in recent years.

Center for Health Policy Research, American Medical Association, Chicago, Illinois, February, 1989

A recently completed study of Medicare claims data for five states for the years 1983 through 1985 reached the following conclusions (West et al., 1988):

- the major sources of growth in OPD services have been expanding use of OPD surgery and growth in the proportion of eligibles receiving services;
- the expanding use of OPD surgery has resulted in increasing the average allowed charge per service across all services, a common measure of "intensity;" and
- aggregate upcoding explains only a small percentage (4%) of the total increase in Part B allowed charges.

These findings suggest that the high rate of Part B expenditure growth is primarily confined to hospital outpatient departments, that patient demand has played a significant role, and that the extent of visit and procedure upcoding is far less than has previously been speculated by some analysts.

CAUSES OF INCREASED VOLUME AND INTENSITY

In the past year, research based on new sources of data has begun to replace speculation with documentation on the causes of Part B volume/intensity growth. Research findings fall into four broad areas:

- patient demand;
- technical innovations in outpatient services;
- third-party reimbursement practices; and
- trends in physician supply.

At a recent research conference on Part B volume growth held by the Leonard Davis Institute for Health Economics of the University of Pennsylvania and jointly sponsored by the AMA, there was much agreement among economists that the nature of volume increases evident in this new information is largely a manifestation of increases in patient demand. Demand effects may be broadly separated into two categories: factors that lower price to the patient at the point of service; and non-price factors that increase the amount of services demanded at a given price. Specific research findings include:

- Over the 1980-87 period, legislation raised the Part B deductible only once and increases in premiums were offset to a large extent by patient savings due to the increase in assignment rates (United States General Accounting Office, 1988).

- The 40-month fee freeze of 1983-1987 allowed inflation to erode the real price of services, as has the subsequent MAAC program which has held fee increases below inflation.

- The prevalence of medigap insurance, which typically provides nearly first-dollar coverage, eliminates the constraints on unnecessary use intended to result from Medicare's cost-sharing provisions. As a result, use of Medicare-covered services is higher than it would otherwise be, and most of the costs of the additional services used are paid by Medicare rather than by medigap insurers. The effect of medigap coverage for the typical Medicare-not-Medicaid enrollee is to increase use of both physician and hospital services by about 24 percent. Over 80 percent of aged Medicare enrollees had either medigap insurance or Medicaid coverage in April 1984 (Christensen et al., 1987).

- As a group, the elderly are economically better off than the younger working-age population. In 1986, the average net worth of households with head of households between 65 and 74 years of age was $249,844, compared to $152,391 for households with head of household between 45 an 64, and $56,563 for households with head between 25 and 44. The greater wealth of elderly households would be expected to contribute to a greater demand for health care services.

- Medicare patients are becoming more aggresive consumers of medical care and more knowledgeable about the availability and benefits of new technology and procedures. For example, in the four months following President Reagan's cancer surgery in 1985, an estimated 73,000 additional colonoscopies were performed on Medicare patients (McMenamin, 1988).

- The biggest source of increase in approved charges per enrollee in recent years has come from outpatient surgery. The convenience of the outpatient setting significantly lowers the time price and the psychic cost to patients, affecting demand similar to a reduction in money price and resulting in a substantial net increase in the numbers of such procedures (West et al., 1988).

Improvements in the provision of medical services has proceeded apace on several fronts and are making the consumption of medical care easier, safer, and more accessible.

- Clinical innovations in outpatient procedures, as for example in cataract surgeries and endoscopies of the digestive system, have resulted in better products and allowing the physician to do more.

- As a result, outpatient services are in fact increasing the cost of U. S. health care in the private as well as public sectors; the Blue Cross and Blue Shield Association found that the number of outpatient visits per thousand people covered jumped 26 percent between 1981 and 1987 and the cost per visit rose 88 percent (Raynor, 1989).

- While the number of visits per person has remained relatively stable, the length of visits and the number and types of services provided has increased; specific examples are found in cardiology, thoracic surgery, gastroenterology, and ophthalmology. (Mitchell et al., 1988)

The insurance industry has been responsible for contributing to the shift to outpatient care. Most insurance companies reimburse 100 percent for outpatient care and 80 percent for inpatient care. (Blue Cross and Blue Shield, however, continues to reimburse 80 percent for procedures regardless of where they are performed.) It is natural for patients to seek out the lowest-cost care setting.

The increasing physician supply has resulted not only in increased access but a reduction in prices of physician services as evidenced by the increasing numbers of salaried physicians and increasing physician participation in PPOs and acceptance of discounted fee-for-service payment (Falk and Langwell, 1988).

PART A VERSUS PART B

Proposed federal budgets for both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

Nevertheless, Part A spending growth in the 1980s has been well below its trend in the 1970s; in contrast, Part B growth has been about the same. The hospital industry has clearly been affected by these Part A cuts, especially in rural areas. The cost-saving effects of the budget acts have been offset by increased utilization of Part B services: 40 percent for OPD services and 15 percent for physician and other Part B services.

CONCLUSION

In many ways, the growth in Part B outlays reflects the success of medicine in making available more and better care to the patient, which in turn has led to increased consumption of medical care:

- Improved techniques are making consumption of medical care easier, safer, and more accessible;
- Patients are being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- More options are being made available to patients, especially outpatient alternatives to inpatient procedures, affording them wider choice among alternative approaches to managing medical problems which they may choose based on personal, subjective criteria.

At the same time, erosion of the cost-sharing provisions of Part B has also resulted in increased growth in demand:

- Constraining fees by limiting MEI updates, freezing fees, and imposing MAACs has resulted in real growth in allowed charges per service below the rate of inflation;
- Medicare allowed charges are now less than 80 percent of physicians' usual fees; and
- The increasing prevalence of medigap insurance and acceptance of assignment neutralizes cost-sharing requirements.

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